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IDENTIFIERS	Family Support; National Association Welfare Res and Stat; Resource and Referral Service; Self Sufficiency; *Welfare Reform

ABSTRACT

The presentations compiled in these proceedings on welfare and self-sufficiency reflect much of the current research in areas of housing, health, employment and training, welfare and reform, nutrition, child support, child care, and youth. The first section provides information on the conference and on the National Association for Welfare Research and Statistics. The bulk of the document contains the proceedings from the 22 sessions of the conference. Titles of papers presented in this proceedings, some of which are just brief summaries, include: (1) "Successful Exits: How Women Leave Welfare Permanently" (Weeks); (2) "What Your Community Can Do about Child Support" (Paulin and Irlbeck); (3) "Paternity Establishment" (Holcomb et al.); (4) "Evaluation of Case Management in Community-Based Long Term Care in Delaware's Department of Health and Social Services" (Anderson); (5) "Managing JOBS Caseloads" (Silverstein); (6) "Services to Runaways and At-Risk Youth" (Calland); (7) "Medicaid Budget Estimation Methods" (Lower); (8) "Justifying Program Funding" (Dodoo); (9) "The Costs and Effects of a Child Support Assurance Program" (Clark); (10) JOBS Initial Evaluation of the Arizona Family Investment Initiative (Dorsey); (11) "Termination of General Assistance in Michigan" (Lovell); (12) "AFFIRM: An Effective Tool in Detecting Fraud and Eliminating Duplicative Aid" (Williams); (13) "New Opportunities, New Responsibilities: Welfare Reform in Wyoming" (Lusk et al.); (14) "Washington State Refugee Self-Sufficiency Initiative" (Vu); (15) "Parents in Transition" (D'Allesandro); (16) "Adolescent versus Older Mothers" (DePanfilis et al.); (17) "Childhood Abuse, Teenage Pregnancy, and Welfare Dependency" (Roper and Weeks); (18) "Win-Win, Electronic Benefit Transfer (EBT) and Health Passport" (Golden and Williams); (19) "Evaluating the Effectiveness of Using Intensive Case Management and Independent Housing To Stabilize the Chronically Mentally Ill Homeless" (Hough); (20) "Patterns of Residential Instability" (Rog et al.); (21) "Cashing Out Food Stamps" (Cohen); (22) "Who Uses Food Assistance Programs?" (Clark et al.); (23) "Health Care Utilization by Children Entering Foster Care" (Risley-Curtiss); (24) "Service Delivery Integration" (Liggett); (25) "Illinois Child Care Resource and Referral Agencies" (Kreader); (26) "Child Support and Automated Information Resources" (Kendall and Dauser); (27) "The Integrated Information System to Support Foster Care" (Benbenishty and Oyserman); and (28) "Reform of Federal Quality Control Systems" (Mills). The last section of the proceedings contains information on participants: biographies, addresses, and an index of participants. (WP)

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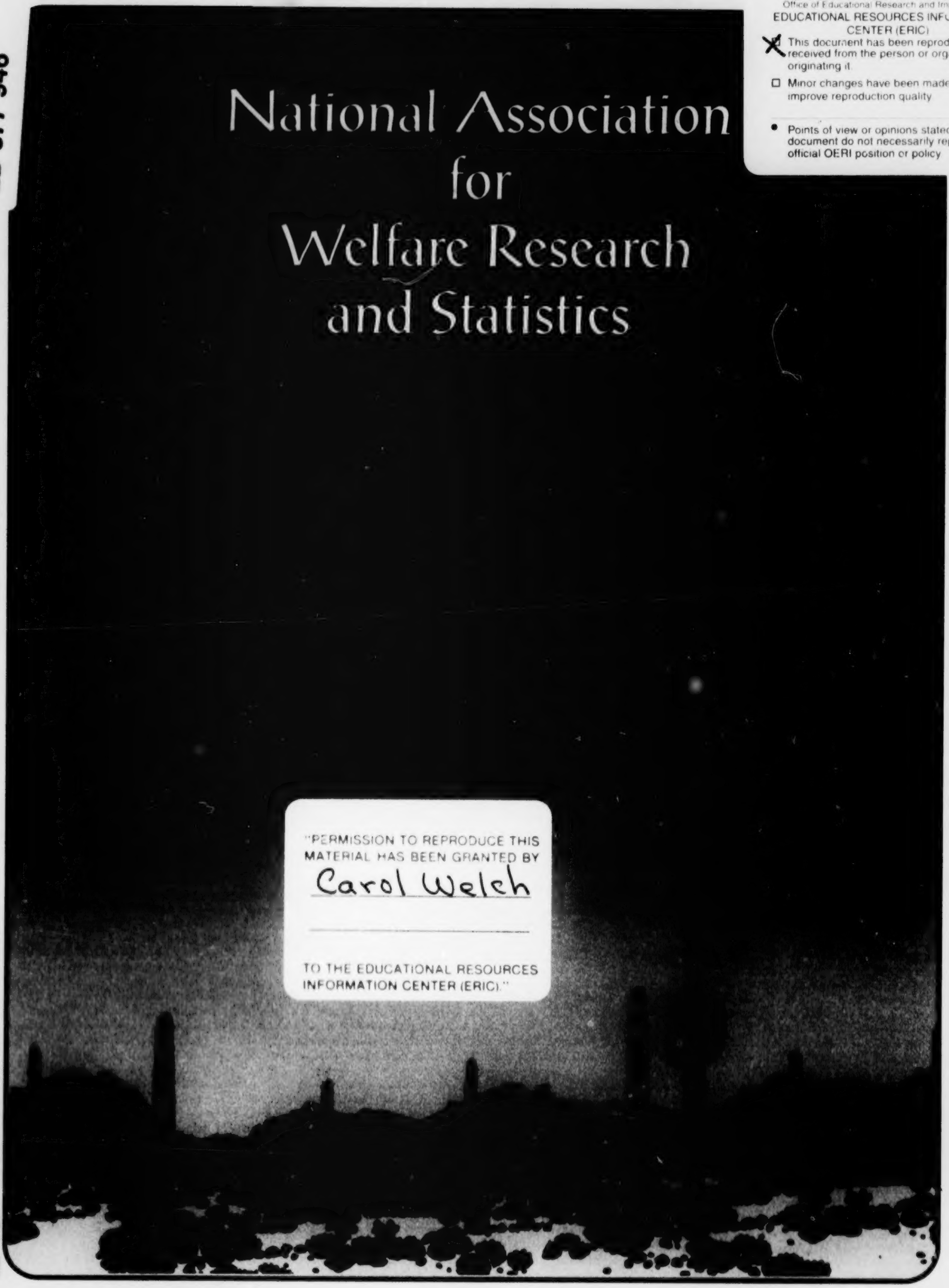
National Association for Welfare Research and Statistics



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Events at the Workshop

Board Activities

Board Meetings
Hospitality Room
Board Breakfast and Dinner Meetings
Business and Caucus Meeting for State Participants
Awards Luncheon and Introduction of 1994 President

Reception

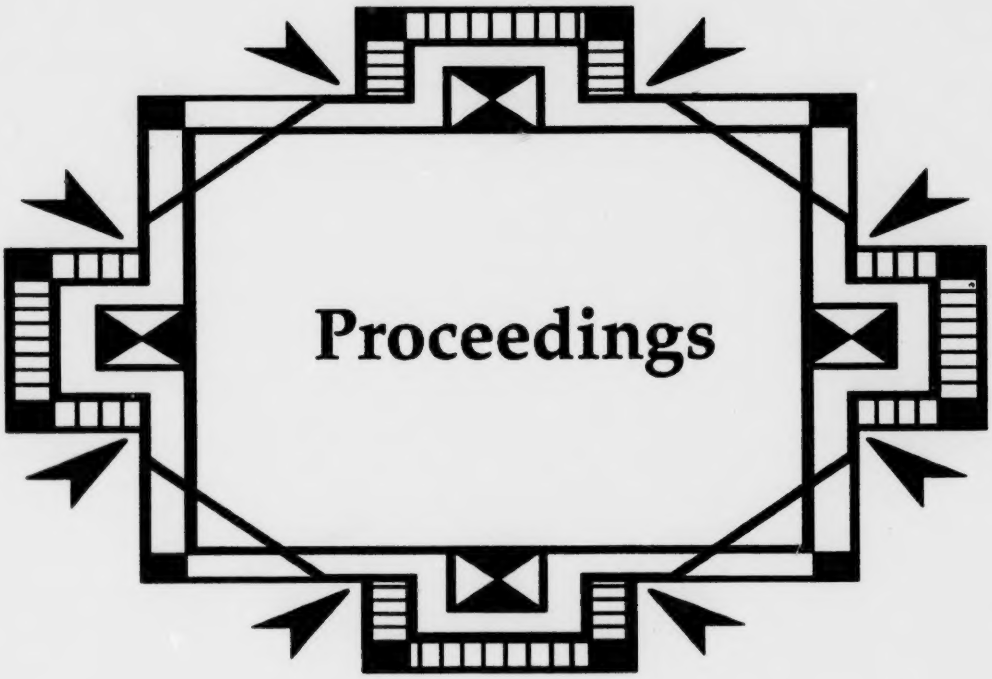
Mexican Fiesta
Mexican Food
Mariachis

Dinner at the Rawhide Steakhouse

Dinner and Western Town Entertainment
Arizona' s Favorite 1880s Western Town
"Best Cowboy Steak"
New York Times Best of Phoenix Award 1990-1991

Workshops and Federal Meeting

Twenty-Two Paper Sessions
Ideas Fair
Event History Analysis Workshop
Federal Regional Meeting



Proceedings

National Association for Welfare Research and Statistics

33rd Annual Workshop:

Toward Self Sufficiency
Social Issues in the Nineties

Wyndham Paradise Valley Resort
Scottsdale, Arizona
August 7-11, 1993

Welcome to Arizona!

Welcome to the beautiful State of Arizona for the Thirty-Third Annual National Association for Welfare Research and Statistics Workshop. You will find this year's conference filled with outstanding papers and informative workshops dealing with welfare reform, JOBS, child support, public assistance, methods for measuring change over time, forecasting turning points in caseload, quality control, and case management.

It is hoped that each of you will take home new ideas, and a renewed sense of commitment to search for new ways to help individuals and families move toward self-sufficiency in the 1990s.

First of all, I am grateful to the contributors, both spontaneous and invited, for their willingness to share their knowledge with others. I would like to extend a special word of thanks to the Program Chair, Carol Welch, and the Program Committee. A final word of thanks goes to the Arizona Department of Economic Security for hosting the conference, the Washington Department of Social and Health Services for supporting the Program Chair, and the NAWRS Board of Directors, who encouraged me to hold the conference in Arizona and have since sustained me with their help and suggestions.

Aldona Vaitkus

Aldona Vaitkus, President
National Association for Welfare Research and Statistics

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Forward

The *Proceedings* includes summaries of presentations made at the National Association for Welfare Research and Statistics (NAWRS) workshop August 7-11, 1993. The 33rd annual workshop was held in scenic Scottsdale, Arizona. The theme of the workshop was ***Toward Self Sufficiency: Social Issues in the Nineties***.

The theme was particularly relevant because of the push for greater reforms in assistance programs. At every level of government, there were concerns that the assistance programs, which had been designed for short-term help, were instead fostering dependence on government programs. Much of the welfare reform efforts, therefore, emphasize moving individuals and families toward self sufficiency. The workshop brought together researchers, policy analysts, and policy makers from the private sector and from state and federal governments. The presentations at the workshop reflected much of the most current research in areas of housing, health, employment and training, welfare, nutrition, child support, child care, and youth. Technical sessions provided updates on automation, error rates and quality control, and methodology. Federal representatives provided their insights on policy issues and where the various programs are headed. The message that came through in each of the sessions is that assistance programs must be knowledge driven, integrated and streamlined in order to provide humane, effective services to an increasingly diverse population with a stable or diminishing resource base.

This year's workshop met its intended goal--to provide a forum for representatives from state and federal governments, universities and research institutes to share their findings and ideas in helping individuals and families move toward self sufficiency. The ideas, experiences and research presented at the workshop provided us with ideas and techniques that can help us sort through the tangled strands of programs, reporting requirements, methodologies, policies, research findings and eligibility requirements to more effectively plan, administer and deliver services.

The Board of Directors of the National Association for Welfare Research and Statistics would like to thank each of the presenters, who made this workshop a success and for the work contained in this document. The Board also expresses its gratitude to the individuals who served as moderators and on the program committee. A special thanks is due to the Arizona Department of Economic Security for hosting the workshop and to the Washington State Department of Social and Health Services for printing the *Proceedings*.

Carol Welch

Carol Welch, Program Chair

Office of the Governor

PROCLAMATION

* NATIONAL ASSOCIATION OF WELFARE RESEARCH AND STATISTICS AWARENESS WEEK *

WHEREAS, [illegible]

WHEREAS, [illegible]

WHEREAS, [illegible]

WHEREAS, [illegible]

NOW, THEREFORE, [illegible]

* NATIONAL ASSOCIATION OF WELFARE RESEARCH AND STATISTICS AWARENESS WEEK *

[illegible]

Fife

[illegible]

History of the National Association for Welfare Research and Statistics

The National Association for Welfare Research and Statistics is a non-profit association organized exclusively for educational and scientific purposes. The purpose of this organization is the promotion of, and the exchange of, ideas for the betterment of research and statistics in the field of public welfare. This is accomplished primarily through an annual workshop of state, federal, and local governmental personnel involved in the field of public welfare along with all other persons of similar interests and concerns.

The Association also welcomes universities and research institutes, which are important in the discussions of research, statistics, public policy, and reporting issues. Each participant, whether a state or federal representative or a university researcher or consultant, has a different perspective and experiences to share with the Association in determining and evaluating public policy and public assistance programs.

The current governing structure, the Board of Directors, was set up at the first meeting in March of 1956. The Board, made up of representatives from each of the ten federal regions, is selected by the state representatives attending the meetings. Since the first meeting, the Board has made a conscious effort to foster a close working relationship between state and federal governments.

The first conference was held at the request of the Acting Director of the Bureau of Public Assistance of the U.S. Department of Health, Education, and Welfare to begin a dialogue between the federal government and state research and statistics directors. Most states and the District of Columbia have been represented by Board members over the past years. The first six meetings were held in Chicago, Denver, and Washington, D.C., reflecting the location of federal, central, or regional offices. Since 1967, the location has been in the home state of the President of the Association to encourage maximum involvement of states.

From the beginning, representatives from across the nation have come together to share experiences and explore ways in which research and statistical data analysis can contribute more effectively to the administration of public assistance programs. Through the years, the scope of human services programs has been expanded to include job training, child support, medical assistance, food stamps, quality control, and other programs that reflect the social issues that must be addressed by policy makers.

The research and analytic methodologies have expanded as new computer technologies have been developed and have become applicable to the social sciences. Recent workshops have included vendors who have software, hardware, and technological advances to share with program participants. This year, we invited researchers and policy makers from both private and public sectors to share their findings and ideas in helping individuals and families move toward self sufficiency.

Officers and Representatives

1993 Officers

President: Aldona Vaitkus, Arizona Department of Economic Security
Program Chair: Carol Welch, Ph.D., Washington Department of Social and Health Services

1993 Program Committee:
David K. Baugh, U.S. Office of Program Systems
Karen Cosby, Kentucky Department for Social Insurance
Joseph S. Golden, Wyoming Department of Family Services
Wilbur A. Weder, U.S. Administration for Children and Families

Secretary: Karen Cosby, Kentucky Department for Social Insurance
Treasurer: Michael Theis, Virginia Department of Social Services

1993 Regional Representatives

	Delegate	**Alternate**
Region I:		
Region II:	Deanna Seabridge, New York	Martey Dodoo, Ph.D., New Jersey
Region III:	Michael Theis, Virginia	Dennis Putze, Pennsylvania
Region IV:	Karen Cosby, Kentucky	Edd G. Thigpen, South Carolina
Region V:	Terry Braun, Ohio	John McPeek, Wisconsin
Region VI:	Jane G. Harrison, Texas	Kathryn Wilkerson, Arkansas
Region VII:	Jerry Bahr, Nebraska	Kent Westmaas, Iowa
Region VIII:	Joseph S. Golden, Wyoming	Bart Hopkin, Utah
Region IX:	Edward Goo, Hawaii	Edward Nishimura, Hawaii
Region X:	Carol Welch, Washington	Robert A. Plue, Washington

Ex-Officio Presidents
Florence C. Odita, Ph.D., Ohio
Samba Sanyang, South Carolina
Monica Zazworsky, Washington

Ex-Officio Program Chairpersons
Dolores L. Torres, Texas
Sandra L. Brown, Georgia
Samba T. Sanyang, South Carolina

1994 Officers

President
Jane G. Harrison, Texas

Honorary Vice President
Dolores L. Torres, Texas

Treasurer
Michael Theis, Virginia

Program Chairperson
Edd G. Thigpen, South Carolina

Secretary
Carol Welch, Washington

1995 President-Elect

Joseph S. Golden, Wyoming

Regions

Region I

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Region II

New York
New Jersey
Puerto Rico
Virgin Islands

Region III

Delaware
Maryland
Pennsylvania
Virginia
Washington, D.C.
West Virginia

Region IV

Alabama
Florida
Georgia
Kentucky
Mississippi
North Carolina
South Carolina
Tennessee

Region V

Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

Region VI

Arkansas
Louisiana
New Mexico
Oklahoma
Texas

Region VII

Iowa
Kansas
Missouri
Nebraska

Region VIII

Colorado
Montana
North Dakota
South Dakota
Utah
Wyoming

Region IX

Arizona
California
Guam
Hawaii
Nevada
American Samoa
North Marianna Islands
Trust Territory of the Pacific Islands

Region X

Alaska
Idaho
Oregon
Washington

NATIONAL ASSOCIATION FOR WELFARE RESEARCH AND STATISTICS
General Business Meeting and Regional Caucuses
33rd Annual Workshop

Scottsdale, Arizona
August 9, 1993

The General Business Meeting of NAWRS at the 33rd Annual Workshop was called to order by President Aldona Vaitkus on August 9, 1993 at 1:30 pm in the South Ballroom at the Wyndham Paradise Valley Resort in Scottsdale, Arizona.

Since the only business to be conducted was the election of Representatives and Alternates to the Board of Directors in odd numbered Regions and the filling of vacancies in several other Regions, Aldona announced those positions which needed to be filled and the states in those Regions. State and local attendees divided into Regions for a 10-15 minute discussion period and then announced the results of their elections to the membership. Aldona announced the need for new members to attend the Board breakfast on Tuesday morning and the closing Board meeting on Wednesday afternoon, both of which were listed in the program.

The election results were as follows:

NEWLY ELECTED 1994 REGIONAL REPRESENTATIVES

Paul Dougan	New Hamsphire	Region I	2 years
Michael Theis	Virginia	Region III	2 years
Dennis Putze	Pennsylvania	Region III Alternate	2 years
Pamela Parnell	South Carolina	Region IV Alternate	1 year
Nancy Wiggins	Minnesota	Region V	2 years
Florence Odita	Ohio	Region V Alternate	2 years
Lea Isgur	Texas	Region VI Alternate	1 year
Jerry Bahr	Nebraska	Region VII	2 years
George Kurian	Colorado	Region VIII Alternate	1 year
Werner Schink	California	Region IX	2 years
Aldona Vaitkus	Arizona	Region IX Alternate	2 years

In addition to the Ex-Officio members, the remainder of the 1994 Board consists of the following Regional members, whose positions are not due for re-election until the 1994 Annual Workshop:

Deanna Seabridge	New York	Region II
Marty Dodoo	New Jersey	Region II Alternate
Karen Cosby	Kentucky	Region IV
Kathryn Wilkerson	Arkansas	Region VI
Bart Hopkin	Utah	Region VIII
Carol Welch	Washington	Region X
Robert Plue	Washington	Region X Alternate

Vacant positions are as follows: Alternate in Regions I and VII

Aldona reminded everyone of the Closing Meeting of the Workshop which is scheduled for Wednesday afternoon at 1:30 pm. The meeting adjourned at about 1:50 pm, at which time the Ideas Fair participants were each invited to describe their respective displays.

Respectfully submitted,

Karen S. Cosby

Karen S. Cosby, Secretary

Guest Speakers, Ideas Fair, Event History and Moderators

Guest Speakers

Joseph F. Cuccia, California Department of Social Services, *State Response to Federal Initiatives*
Henry Dreifus, Dreifus Associates, Ltd., *Electronic Benefit Transfers*
Karen Greene, U.S. Department of Labor, *Integrating Programs*
Monsignor Ryle, Arizona Catholic Conference, *Invocation*
Bill Soderquist, Vice Mayor, City of Scottsdale, *Welcome to Scottsdale*
Bonnie Tucker, Arizona Department of Economic Security, *Total Quality Management*
Vince Wood, Arizona Department of Economic Security, *Introductions*

Ideas Fair Presenters

- *34th Annual NAWRS Workshop--Austin, Texas.* Dolores L. Torres and Deborah E. Anderson, Texas Department of Protective and Regulatory Services
- *Finger Imaging Identification Technology--The Future is Now.* Elie Aslan, The National Registry
- *Food Stamp Insertion Equipment.* Elvis DeFreitas, Bell and Howell Phillisburg Company
- *Quality Control Management Information System (QCMIS).* Robert E. Schneider, Ph.D., Micro Services, Inc.

Event History Analysis Workshop. Felix D'Allesandro and Gregory C. Weeks, Ph.D., Impact

Moderators

Terry D. Braun, Ohio Department of Human Services
Sandra L. Brown, Georgia Department of Human Resources
John F. Cosby, Jr., Kentucky Legislative Research Commission
Karen S. Cosby, Kentucky Department of Social Insurance
Martey S. Dodoo, Ph.D., New Jersey Department of Human Services
Joseph S. Golden, Wyoming Department of Family Services
Tim Hogan, Ph.D., Arizona State University
Bart Hopkin, Utah Department of Human Services
Richard L. Hough, Ph.D., San Diego State and University of California
Jean Irlbeck, J.D., Paternity Acknowledgement Associates, Inc.
Ellen Konrad, Arizona Department of Economic Security
Gretchen Locke, Abt Associates, Inc.
Florence C. Odita, Ph.D., Ohio Department of Human Services
Dennis Putze, Pennsylvania Department of Public Welfare
Jeffrey J. Repichowski, New Mexico Human Services Department
Deanna Seabridge, New York State Department of Social Services
Michael J. Theis, Virginia Department of Social Services
Edd G. Thigpen, South Carolina Department of Social Services
Dolores L. Torres, Texas Department of Protective and Regulatory Services
Yasmina S. Vinci, The National Association for Child Care Resource and Referral Agency
Wilbur A. Weder, U.S. Department of Health and Human Services
Kathryn A. Wilkerson, Arkansas Department of Human Services
Morris Williamson, Texas Department of Human Services

RECIPIENTS OF AWARDS

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1993 Special Awards Recipients

Jane G. Harrison, Director, Program Statistics, Texas Department of Protective and Regulatory Services, presented by Dolores Torres, 1992 Program Chair

Each year the NAWRS Board of Directors chooses to honor selected persons who have made outstanding contributions to the Association or to the field of welfare research and statistics, in general. This year, both of our recipients easily fulfill both criteria. I am very proud to announce that Jane G. Harrison is one of this year's recipients. Jane has been very active in NAWRS over the years. Her versatile background in understanding the statistical and research applications of data and of the systems, storage and retrieval of the raw data have enabled her to provide names, organizations, projects and issues to be incorporated into the workshop programs.

I think it is fitting that Jane attended her first NAWRS workshop in Arizona in 1977 and has remained a member of the Association since that time. She has been a Board member since 1985, and in 1986, she was the Program Chair in Virginia. Just having completed that task in Ohio myself, I know how big a job Program Chair can be. But Jane was not content to sit back on that accomplishment. Jane has now taken on the job of President-Elect and will host the 1994 workshop in Texas. On behalf of the National Association for Welfare Research and Statistics and its Board, for gratitude of service, I present this award to Jane G. Harrison!

James 'Will' Lowery, Deputy Director, Mississippi Division of Medicaid , presented by Karen Cosby, 1993 Secretary

I am honored to have the opportunity to present our other 1993 Special Award to James 'Will' Lowery. Will has been with the Department of Medicaid since 1970. He first attended a NAWRS Workshop in Nashville, Tennessee in 1981 when he became involved with Quality Control. Because of his care with the Medicaid Department in Mississippi, his boss gained such confidence in his abilities that he was usually given the task of getting most programs off to a good start. Thus, it was when he moved into the budgeting areas that he really began to see the value of NAWRS. Since the 1981 Workshop, he has attended every year except one when major surgery prevented him from doing so. For many of us, seeing him each year and his gracious wife, Minnie Mae, is one of the highlights of each year's workshop.

Throughout these 13 years, Will has been a strong advocate for NAWRS. Furthermore, Will has always promoted improved relations with federal agencies and a strong partnership between "feds" and the states. At a number of the workshops, tensions between the two groups has sometimes run high. But Will always helped ease the way. Last year, we had a chance to hear Will speak at a Plenary Session on Medicaid funding issues. Somehow, he managed to tackle a very contentious issue without creating more tension, and his delightful manner kept us all entertained. We certainly need to tap into his wisdom and wit far more often.

To top it all off, Will is one of the nicest, friendliest persons you will ever meet. To quote from Editha Ponder's 1974 history of NAWRS: *To many of us the organization has become an important force in our lives, not only for professional relationships, but also in terms of life-long friendships. This relates to families as well.* You certainly will not find anyone who embodies this more than our dear friend and colleague, James 'Will' Lowery. Congratulations, Will, on your long and successful career and thanks for your contributions to NAWRS!

Previous Special Awards Recipients and Workshops

Previous Special Awards Recipients

1992 Wilbur Weder, HHS
Richard Wheelock, UT

1991 Jerry Bahr, NE
David Baugh, HCFA
Karen Cosby, KY

1990 J. Barry Schaub, MD

1989 L. Marjorie Barker, KY

1988 Roy Butler, KY
Robert Mugge, HHS
Howard Oberheu, HHS

1987 Timothy Baker, PA
Ruth Coogan, RI
Alma Cox, MS
Edward C. Pirie, VT
Editha Ponder, HCFA

1986 John Belville, FL
Carl Sitter, VA
Melba Smith, MS

1981 Wayne Epperson, IL
Margaret Jordan, AL
Alan Leggett, TX
Sue Osmond, OFA
George Richards, LA

Past Workshops

Year	President or Chair	Site
1992	Florence Odita	Columbus, OH
1991	Samba Sanyang	Charleston, SC
1990	Monica Zazworsky	Bellevue, WA
1989	Dave Thorsen	Kalispell, MT
1988	J. Barry Schaub	Baltimore, MD
1987	L. Marjorie Barker	Louisville, KY
1986	Susan P. Polyson	Richmond, VA
1985	Jerry Bahr	Lincoln, NE
1984	Patricia Day	Hartford, CT
1983	Alma Cox	Jackson, MS
1982	Tom Suehs	San Antonio, TX
1981	Gary McDonald	Nashville, TN
1980	Joseph Gale	Madison, WI
1979	Richard Wheelock	Salt Lake City, UT
1978	Charles N. Wagner	Savannah, GA
1977	Wallace P. Earle	Phoenix, AZ
1976	George Richards	New Orleans, LA
1975	Ira Gunn (NV)	San Francisco, CA
1974	Edward C. Price (VT)	Boston, MA
1973	Wayne Epperson (IL)	Denver, CO
1972	Alan Leggett (TX)	Washington, DC
1971	Robert R. Cline (WV)	Las Vegas, NV
1970	Raymond Freeman (CO)	Washington, DC
1969	George Richards (LA)	New Orleans
1968	ElMoine Kirkham (UT)	Washington, DC
1967	W.L. Parker	San Francisco, CA
1966	Edson K. Labrach (ME)	Washington, DC
1964	Editha M. Ponder (NC)	Washington, DC
1962	Gidson A. Hample (ND)	Washington, DC
1960		Denver, CO
1958		Chicago, IL
1956	Sam Carter (LA)	Chicago, IL

Welfare Reform I

Moderated by Wilbur A. Weder
Administration for Children and Families

Successful Exits: How Women Leave Welfare Permanently - Gregory C. Weeks, Ph.D., Washington Institute for Public Policy

The Washington State Family Independence Program: Welfare Reform at Two Years - Sharon K. Long, Ph.D., The Urban Institute [Oral presentation only]

California Demonstrations: A Comprehensive Approach to Welfare Reform - Michael Genest, California Department of Social Services [Oral presentation only]

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Successful Exits: How Women Leave Welfare Permanently

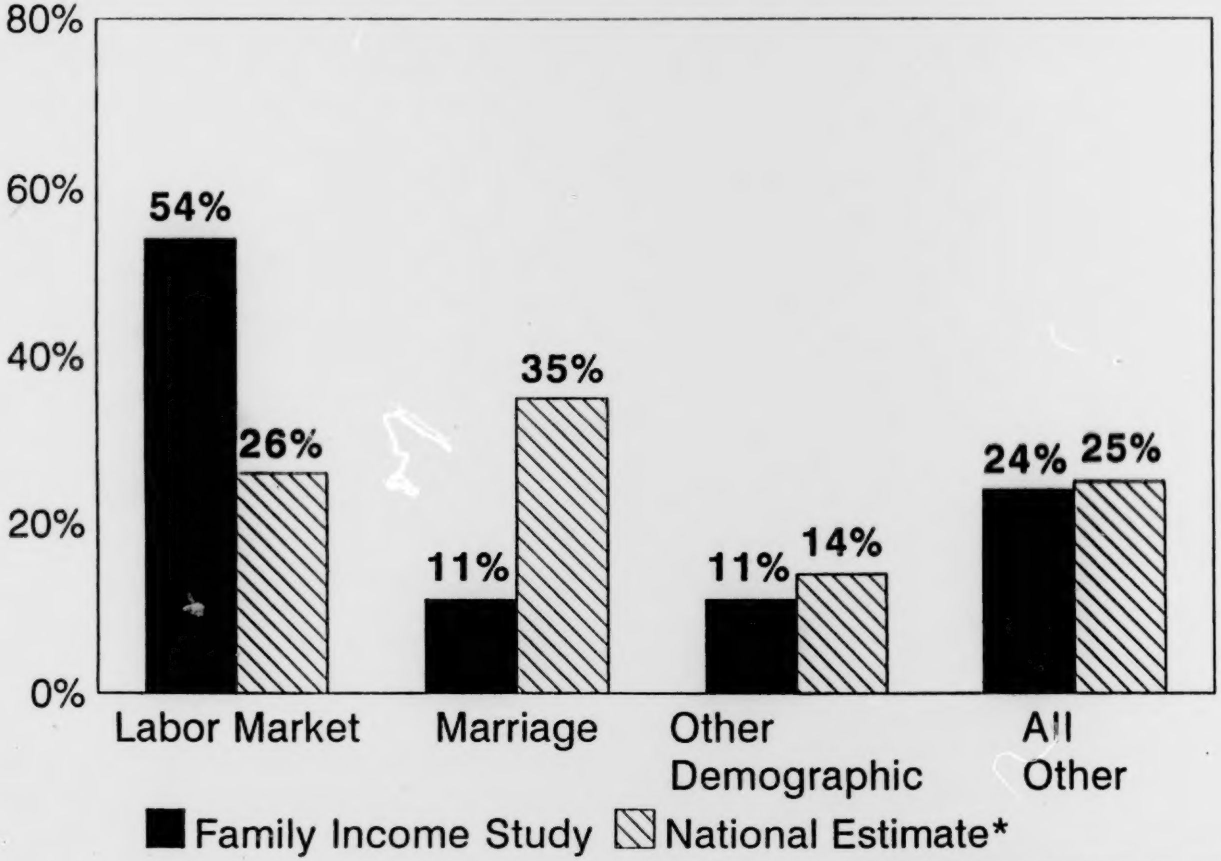
Gregory C. Weeks, Ph.D., Washington State Institute for Public Policy

This study used discrete decision models and hazard models to determine what characteristics are associated with short-term welfare use, long-term welfare use and repeated spells of welfare. Policy implications are discussed.

The following pages were presented at the conference. For further information regarding this study, please contact the author (see list of addresses).

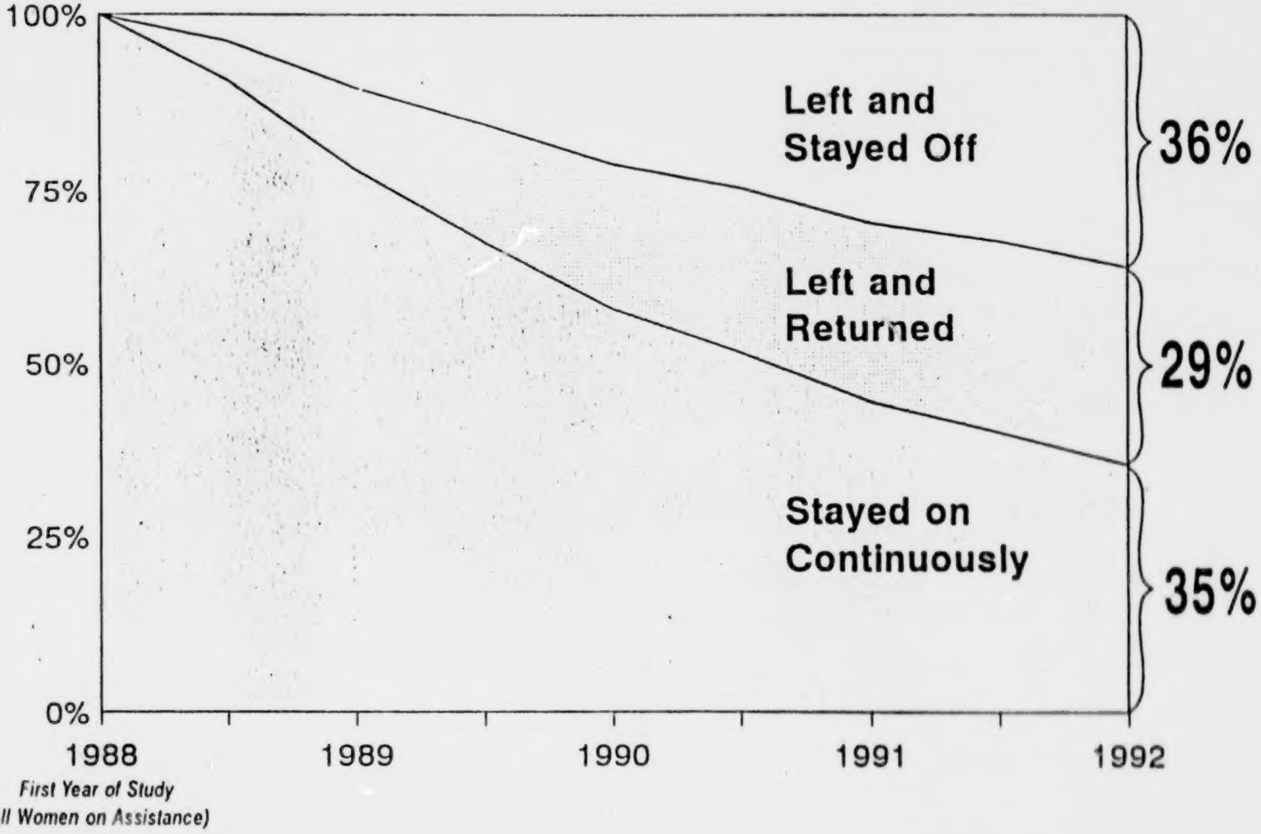
DRAFT

Why Women Left Public Assistance
(self-reported)



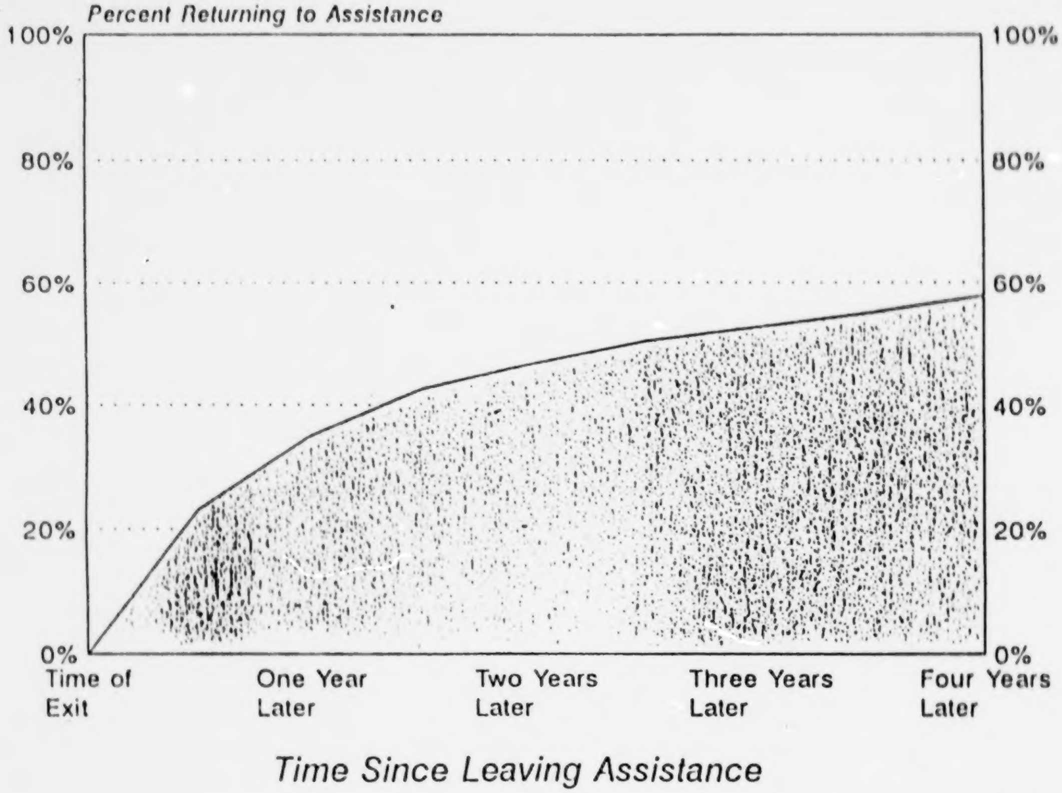
**David T. Ellwood, "Targeting the 'Would-Be' Long-Term Recipients of AFDC," 1986.*

Many Exits from Public Assistance Were Temporary



DRAFT

Over Half of the Women Who Left Public Assistance Returned Within Three Years



DRAFT

Exit Logit Estimates
Stacked Family Income Study Data
1988-1992

```
Number of obs =    3251
chi2(14)      = 706.88
Prob > chi2   = 0.0000
Log Likelihood = -1896.3791
Pseudo R2     = 0.1571

-----------------------------------------------------------------
exit :     Odds Ratio     Std. Err  t     P>t
---------+-------------------------------------------------------
duration* :    .9843046   .0009986   -15.593     0.000
     age  :   1.007188    .0052752     1.367     0.172
  educat* :   1.061824    .0173899     3.663     0.000
  totchd* :    .8838826   .0304312    -3.585     0.000
  infant  :   1.027078    .1344873     0.204     0.838
 multadt* :   1.604428    .1401345     5.413     0.000
  maried* :   2.174694    .3142981     5.375     0.000
     swd**:   1.21538     .1206433     1.965     0.049
  employ* :   2.150677    .1774784     9.280     0.000
   black* :    .5053985   .0900766    -3.829     0.000
 othrace**:    .7816289   .0874781    -2.201     0.028
     wnm  :   1.060907    .138507     0.453      0.651
      em* :    .7096844   .0764722    -3.183     0.001
     enm  :    .9955741   .1199587    -0.037     0.971
-----------------------------------------------------------------
* significant at 0.01; ** significant at .05
```

Factors That Significantly Influenced The Likelihood of Leaving Public Assistance

Factors that *increased* the likelihood of leaving public assistance:

- Years of education,
- Living in a household with other adults, regardless of marital status
- Being married
- Being separated, widowed or divorced (as opposed to being never married)
- Having employment for pay in the previous year

Factors that *decreased* the likelihood of leaving public assistance:

- Length of time on public assistance.
- Having more children in the household
- Being non-white or Hispanic
- Living in a metropolitan Eastern Washington County.

DRAFT

Return to Public Assistance
Logit Estimates
Stacked Family Income Study Data
1988-1992

```
Number of obs =    1210
chi2(14)      = 550.11
Prob > chi2   = 0.0000
Log Likelihood = -512.30198
Pseudo R2     = 0.3493

--------------------------------------------------------------------

  return : Odds Ratio   Std. Err.       t      P>:t:
---------+----------------------------------------------------------
duration*  :    .9147545   .0051973    -15.682   0.000
     age*  :    .9571649   .0107188     -3.909   0.000
  educat@  :    .9366174   .0313452     -1.957   0.051
  totchd*  :    1.270159   .0866626      3.505   0.000
  cldbrn   :    1.305345   .3653555      0.952   0.341
 multadt*  :    .5298894    .107889     -3.119   0.002
  maried*  :    .4620838    .116154     -3.071   0.002
     swd@  :    .6739045   .1574408     -1.689   0.091
  mnswrk*  :    .9173524   .0149486     -5.294   0.000
   afram   :     .483701   .2156017     -1.629   0.103
 othrace*  :    .3658314   .0986052     -3.731   0.000
     wnm   :    .8611435    .207983     -0.619   0.536
    enm*   :    1.937481   .4846901      2.644   0.008
     em    :    1.435441   .3262364      1.590   0.112
--------------------------------------------------------------------
```

Factors That Influenced Returning to Public Assistance After Leaving

Factors that *increased* the likelihood of returning to public assistance after leaving:

- **More children in the household.**
- **Living in an Eastern Washington, non-metropolitan county.**

Factors that *decreased* the likelihood of returning to public assistance after leaving:

- **Length of time *off* public assistance.**
- **Having more months of paid employment in the previous year.**
- **Being older.**
- **Having more years of education.**
- **Living in a household with other adults, regardless of marital status.**
- **Being married.**
- **Being separated, widowed or divorced (as opposed to being never married).**
- **Being neither white nor African American.**

DRAFT

Persistent Exit Logit Estimates
Stacked Family Income Study Data
1988-1992

```
(Persistent Exit defined as leaving for at Least 24 Months)

Number of obs =    2923
chi2(14)      = 286.01
Prob > chi2   = 0.0000
Log Likelihood = -583.78612
Pseudo R2     = 0.1968

------------------------------------------------------------------
permexit : Odds Ratio   Std. Err.        t      P> t
------------------------------------------------------------------
     age   :   1.000577   .0096344      0.060    0.952
  totchd** :   .8249325   .0652842     -2.432    0.015
  cldbrn@  :   .5474015   .1762442     -1.872    0.061
  employ*  :   4.075447   .7102184      8.062    0.000
  educat*  :   1.140133   .0436929      3.422    0.001
  maried*  :   4.537674   1.178911      5.821    0.000
     swd@  :   1.531422   .3584972      1.821    0.069
  afriAm** :   .2730099   .1644926     -2.155    0.031
 othrace   :   .8335889   .2120297     -0.716    0.474
 multadt*  :    1.84248   .3568592      3.155    0.002
     wnm   :    .709622   .1786719     -1.362    0.173
      em   :   .8750411   .1898753     -0.615    0.538
    enm@   :   .6332995   .1574148     -1.838    0.066
duration*  :   .9869264    .002373     -5.473    0.000
-----------------------------------------------------------------
* significant at 0.01; ** significant at 0.05;
@ significant at 0.10.
```

These Factors Influenced The Likelihood of Leaving Public Assistance for 24 or More Months

These Factors increased the likelihood of a persistent exit from public assistance:

- Being employed for pay in the previous year.
- Years of education.
- Being married.
- Being separated, widowed or divorced (as opposed to being never married).
- Living in a household with other adults, regardless of marital status.

These Factors decreased the likelihood of a persistent exit from public assistance:

- Length of time on public assistance
- Having more children in the household.
- Having an infant in the household.
- Being African American.
- Living in an Eastern Washington non-metropolitan county.

The Washington State Family Independence Program: Welfare Reform at Two Years

Sharon K. Long, Ph.D., The Urban Institute

This study evaluated a pre-JOBS welfare-to-work program in Washington state, the Family Independence Program (FIP). FIP was intended to improve the state's welfare system by redefining the interaction among income maintenance, education and training activities, employment and supportive services available to AFDC recipients.

For further information regarding this study, please contact the author (see list of addresses).

California's Demonstrations: A Comprehensive Approach to Welfare Reform

Michael Genest, California Department of Social Services

Faced with a third consecutive year of fiscal crisis, California has embarked on an extensive set of efforts to control caseload growth. California's reforms encompass changes to AFDC benefit amounts, GAIN (JOBS), work incentives (fill the gap budgeting, 100 Hour Rule and $30 and 1/3 exemptions), child care, child support, fraud and quality control reform, statewide automation, and a variety of administrative cost saving strategies. The issues, the players and negotiations translate into new directions for demonstration projects in California.

For further information regarding this study, please contact the author (see list of addresses).

Paternity Establishment

Moderated by Jean Irbeck, J.D.
Paternity Establishment Associates, Inc.

What Your Community Can Do About Child Support: How To Use the Health Care System to Improve Paternity Establishment - Barbara A. Paulin, Delaware Health and Social Services, with Jean Irlbeck, J.D., Paternity Establishment Associates, Inc.

Paternity Establishment: Variations in Practice and Promising Approaches to Effective Performance - Pamela A. Holcomb, Freya L. Sonenstein, Ph.D., and Kristin S. Seefeldt, The Urban Institute

Federal Regulation Update and Description of Current Trends in Paternity Establishment - Jean Irlbeck, J.D., Paternity Establishment Associaties, Inc. [Oral presentation only]

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What Your Community Can Do about Child Support: How to Use the Health Care System to Improve Paternity Establishment

Barbara A. Paulin, Delaware Health and Social Services, with Jean Irlbeck, J.D., Paternity Establishment Associates, Inc.

I. Paternity Establishment

A. Introduction

In keeping with its mission of reducing dependency, the Delaware Department of Health and Social Services seeks to **increase the rate of paternity establishment and shorten the process involved in establishing child support orders**. Early intervention with one or both parents is seen as a logical approach to achieving these objectives. Accordingly, in a cooperative effort between the Department's Divisions of Public Health and Child Support Enforcement, **unwed clients who chose to participate received early education and intervention about paternity in prenatal clinics**, under the premise that expectant mothers who are educated about paternity may encourage expectant fathers to acknowledge paternity. Delaware's project provided both parties time to "think about" the responsibilities and consequences of acknowledging paternity. The hope was that our approach of educating both parties would result in a high number of paternity admissions and a low rate of parentage appeals.

B. Background

The problem of welfare dependency in the United States is largely a problem of the non-support of children by their non-custodial parents. **A child's right to support from its father is unenforceable until paternity is legally determined.** Once paternity is legally established, a child born out of wedlock has the same right to support as one born to married parents. Our society recognizes maternal relationships of children born out of wedlock as legal; paternal relationships, however, are not recognized until the often cumbersome process of establishing paternity can be completed.

Child support enforcement programs understandably place high priority on establishing paternity. Recent federal legislation has put increasing pressure on states to firm up their practices and increase their effectiveness in accomplishing key outputs, such as paternity establishment. The Family Support Act of 1988 (P.L. 100-485) imposed additional requirements to encourage improved performance. States were expected to meet strict federal standards for the establishment of paternity, and a baseline rate was determined. Now, each state **must meet a performance level** which either:

- equals or exceed fifty percent (50%); or
- is three (3) percentage points greater than the 1988 baseline in each successive year beginning with 1990; or
- is equal to the percentage determined with respect to all states for that year.

Some of the other provisions of the Family Support Act which affect paternity establishment are discussed below:

Case Processing Time Frames

Within no more than 90 days of locating the alleged father, a state must file for paternity establishment or complete service of process to establish paternity, or document unsuccessful attempts to serve process. **Paternity must be established or the alleged father excluded by genetic testing or legal process or both, within one year of successful service of process or the child reaching 6 months of age, whichever is later.** The state must meet the same time requirements whenever successive alleged fathers must be identified.

Genetic Testing

Upon the request of any party in a contested paternity case, **all parties involved must submit to genetic testing**. The federal government pays for 90% of all testing-related expenses. Testing laboratories are selected competitively. Costs may be recovered from certain individuals.

Interstate Processing

When more than one state is necessarily involved in a paternity case, explicit case processing time frames apply to the initiating and responding state. **Long arm jurisdiction is used whenever appropriate to avoid the lengthy interstate processing network.**

C. Benefits of Paternity Establishment

The numerous **benefits** of paternity establishment **include** the following:

Financial Advantages

Primary responsibility to provide for the needs of children is placed upon both parents, rather than the taxpayers. Consequently, **paternity establishment promotes self-sufficiency** and enables the child to benefit from the standard of living provided by both parents.

Social Entitlement

Paternity establishment is an essential element of a child's eligibility for many public and private benefits stemming from the father-child relationship. These benefits include Social Security in the event of the father's death, disability or retirement during the child's minority; military allotments, health and educational benefits; and the right to seek recovery in wrongful death situations.

Emotional and Psychological Benefits

Establishing a father-child relationship **fosters a sense of identity and self-esteem for the child** and provides knowledge of the family heritage, ancestry, and cultural and religious ties. Paternity establishment is also pivotal in asserting custody and visitation rights.

Medical Interests

A variety of diseases, birth defects, and other disorders are genetically transmitted to children by their parents. These conditions may not be detected or prevented without knowledge of the family history.

II. Paternity Establishment in Delaware

A. Current Process of Establishing Paternity

The Delaware Family Court obtains jurisdiction by having the alleged father served with a "new support" petition. The petition seeks to establish the legal duty to support, establish a support amount, and obtain health insurance. Paternity is inherent in the duty to support. After jurisdiction is obtained, a mediation hearing is scheduled to attempt to work out an agreement between the parties. If the alleged father admits paternity, he then signs a Stipulation of Paternity, and a consent order is issued. The case then moves into collection status, where it will be monitored by the Division of Child Support Enforcement's automated system, DACSES, and brought to the attention of a worker if payments are not forthcoming as ordered.

If paternity is denied, blood testing is scheduled. If testing does not exclude the father, but he still denies paternity, the matter is then escalated to a Family Court Master or Judge for adjudication. If the Court finds the father to be the natural father, a support order is then entered. If the alleged father is found not to be the natural father, the mother is asked to name another putative father and the process is repeated.

B. Paternity Establishment Pilot Project

The federal mandate to increase paternity establishments, coupled with Delaware's out of wedlock birth rate, triggered Delaware Health and Social Services to look for an innovative approach to increasing its paternity establishment rate. The result was the development of a health-related paternity establishment project targeted at unwed expectant mothers during the prenatal period. It is well documented that when the paternity establishment process is started early, before or immediately after birth, the probability of success is much greater than when paternity is addressed later as part of establishing a support order. There is less opportunity for the father to estrange himself from the child and less time for the mother to distance herself and the child from the father.

In a cooperative effort between the Delaware Health and Social Services' Divisions of Public Health (DPH) and Child Support Enforcement (DCSE), a pilot project was implemented at the Northeast State Service Center in Wilmington, on January 2, 1992. The project involved integrating the paternity establishment process into the educational component of the comprehensive prenatal care program provided by DPH.

C. Project Goals

The project had **two goals**.

1. Increase paternity establishment for out of wedlock births.
2. Educate unwed expectant mothers on the advantages of establishing paternity as soon the child is born.

D. Project Procedures

Late in the pregnancy, the DPH social worker was to counsel each unwed client, stressing the importance of knowledge of the father's biological background. **Information about the paternity establishment project and DCSE child support services was to be provided, and clients were to be encouraged to talk with the expectant father about establishing paternity**. The following steps were to take place:

1. A paternity information package is provided to each unwed client, containing a Child Support Services brochure and a Paternity Establishment brochure.
2. The social worker completes a referral form, which includes information on both the expectant mother and expectant father and indicates the expectant mother's consent to participate.
3. The referral form is sent to the DCSE Paternity Specialist, who contacts the expectant mothers who have agreed to participate.
4. After the baby is born, the mother and alleged father are interviewed by the DCSE Paternity Specialist. If the father agrees to acknowledge paternity voluntarily, the DCSE Paternity Specialist will review the Admission of Paternity form, explaining the father's rights (to a blood test, etc.) and the ramifications of signing the Admission. Both parents sign the Admission. The document will be notarized.
5. If the mother opts to file an application for child support services, DCSE will file a petition for determination of paternity/new support. The Admission of Paternity will be attached to the petition. The Delaware Family Court will accept the Admission as a rebuttable presumption of paternity.

6. If the mother does not file an application for child support services, the Admission will be kept on file for use if a paternity determination petition is filed in the future.

III. Evaluation Outcomes

A. Data Collection

The referral form served as the data collection instrument. All necessary information was recorded on the form. **Data was collected from January 2, 1992 through December 31, 1992.** The following data was collected:

- Number of persons interviewed by the DPH social worker.
- Number of people who agreed to participate.
- Reasons for non-participation.
- Number of referrals contacted by the DCSE Paternity Specialist.
- Number of referrals who applied for DCSE services.
- Number of alleged fathers who voluntarily signed the Admission of Paternity.
- Number of cases in the project with paternity establishment.

B. Findings Relative to Original Goals

An evaluation of the project was performed by an independent contractor, Paternity Acknowledgement Associates (PAA), based on an analysis of ninety-six (96) cases, with a final report submitted in June of 1993. The findings cited below stem from that evaluation report by PAA. The evaluation showed that **one of the original goals of the project, that of obtaining a significant number of Admissions of Paternity signed by unmarried parents, was not met,** i.e., only two Admissions were signed. Since the thrust of data collection had been assessment of progress toward that goal, it was therefore difficult to draw conclusions not directly related to that original goal. **However, the project,** characterized by the evaluators as "a unique opportunity to learn about some behaviors and attitudes among this population", **was able to provide some "useful indicators... of potential outcomes for future related efforts".**

Evaluators were also able to qualitatively address the project's efficacy with respect to the second major project goal, that of educating unwed expectant mothers on the advantages of establishing paternity. Although not formally recorded on the referral form completed for each of the interviews, the social worker who conducted the interviews found that:

- Some expectant mothers tended to be more interested in establishing paternity **after** a discussion of the benefits than they were prior to that discussion.
- Others were more interested after taking the information home and reviewing it.
- A few expectant mothers decided to participate after consulting with the alleged father.
- The more information available to participants, the more comfortable they became with the issues.
- Majority of expectant mothers felt confident that the man they named was the biological father, they had a positive relationship, and they expected it to continue.
- It seemed very important to both expectant mothers and fathers that the man be named on the birth certificate.

The social worker felt that the expectant mothers were very open and honest in making these comments, and, in the judgement of the evaluators, the social worker's perceptions can be considered reliable because of her excellent insights and her ability to instill confidence and ease while discussing sensitive issues. The referral form did record willingness to participate and, if the individual wished, more specific comments. **Thirty-four (34%) of the expectant mothers made a statement that expressed a strong interest in establishing paternity**.

The social worker and her supervisor felt strongly that the discussion of paternity and related issues did not affect the expectant mothers use of prenatal medical care. Those who left this clinic did so mostly because they either moved out of the area or were transferred to another facility for specialized high risk care.

C. Other Findings

Ages of the Participants

- Thirty (30) of the ninety-six (96) expectant mothers **(31%) were seventeen (17) years of age or younger.**
- **The highest age category of participants was 20-24**, with 16 participants (17%). corresponding to the general population in Delaware and the United States.
- Alleged fathers for whom age was known tended to be older.

- Of the thirty-nine cases in which ages of both were known, **only three couples (8%) were both minors.**

- **The highest age category of alleged fathers was also 20-24,** with 12 or 21% of those for whom ages were known.

Information Obtained at the Prenatal Clinic

- 83 of the 96 expectant mothers **(86%) gave an alleged father's first and last name at the prenatal clinic;** of the 13 remaining, some did not provide a name due to existence of more than one possible father.

- 18 of those naming a father lived with him at the time of the interview.

- **63 of the expectant mothers provided the alleged father's full address, 59 provided his telephone number, 15 provided his social security number, and 7 provided information about his place of employment.**

- **There was no significant difference by age in the amount of information provided by expectant mothers.**

- The timing of the interview also had no significant impact on information provided.

Mothers on AFDC and Medicaid

- **58 of 96 participants had a record of AFDC usage during 1992-3; 77 participants were on Medicaid.**

- Of these 58, 48 **(83%) named the alleged father at the prenatal clinic.** This compares to 97% for expectant mothers with no record of AFDC usage.

- No significant differences in naming alleged fathers existed between Medicaid and non-Medicaid recipients.

Children Using the Father's Last Name

- Follow-up after birth revealed that, **in 35 of the 96 cases (36%), the children were given the alleged father's last name.**

- In these 35 instances, 74% **had given the alleged father's address at the clinic**, and all of these alleged fathers lived in Delaware.
- In 24 of these cases, the expectant mother and alleged father were not living together at the time of the interview.
- In 40 cases, the mother's last name was given the child; in the remainder of cases, the name was not discovered.

Follow-up by the DCSE

DCSE specialists followed up after confirmation of the child's birth date and attempted to contact by telephone or letter the ninety-six (96) mothers who had agreed to participate in the project. **Of the total of 96, seven (7) responded, but only two (2) followed through with the appointments, with Admissions being signed in both cases.**

IV. Recommended Next Steps

Recommendations arising from the evaluation include the following:

- The prenatal clinic paternity **project should be expanded to all Public Health clinics in the state** which provide prenatal services, with consideration for subsequent expansion to private clinics.
- Written **informational materials should be revised** to better highlight issues of importance to the expectant mothers, and confidentiality should be better emphasized.
- **Social workers/interviewers should receive additional training** in child support program procedures and how best to present and elicit information.
- **Data forms and the data collection process should be revised** to facilitate follow-up, automated referral from the prenatal clinics, and future program evaluation (one year following full implementation).
- **More intensive follow-up is needed** to increase the number of Admissions of Paternity.
- Planning should begin for a **hospital**-based paternity program to complement, not replace, the prenatal clinic program.

DELAWARE OUT OF WEDLOCK BIRTHS

STATISTICS

- 3,221 babies were born to single mothers in 1990. This represented 28.9% of the live births in Delaware that year.
- 27.9% of the births during the 5-year period from 1986 through 1990 were to single mothers.
- The 5-year average percentage of births to single mothers was 74.7% for mothers under the age of 20.
- The percentage of births to single mothers has increased over the last decade, with Delaware's percentage being consistently higher than the nation as a whole.

SOURCE: Delaware Vital Statistics Annual Report, 1990, Delaware Health and Social Services.

Paternity Establishment: Variations in Practice and Promising Approaches to Effective Performance

Pamela A. Holcomb, Freya L. Sonenstein, Ph.D., and Kristin S. Seefeldt, The Urban Institute

The information presented herein is a synthesized and shortened version of two existing papers: "Paternity Establishment in 1990: Organizational Structure, Voluntary Consent, and Administrative Practices" (1992) by Pamela Holcomb, Kristin Seefeldt, and Freya Sonenstein and "Promising Approaches to Improved Paternity Establishment Rates at the Local Level" (1993) by Freya Sonenstein, Pamela Holcomb, and Kristin Seefeldt. Funding for this project was provided by grants from the Ford Foundation and the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Opinions expressed do not necessarily represent the views of the Urban Institute or the project's funders.

Introduction

Paternity establishment is the legal process by which men who father children outside of marriage assume the rights and responsibilities of parenthood. It has increasingly become the focus of policy makers and child support program officials because of inter-related concerns about the escalating rates of non-marital births and the high incidence of poverty and welfare dependency associated with single female-headed families. One strategy employed to reduce poverty and welfare dependency has been to strengthen the nation's federal-state child support enforcement (IV-D) program. Paternity establishment plays a vital role in this strategy since child support cannot be ordered or enforced until the paternity of a non-marital child is legally established.

Statistics can illuminate the nature and magnitude of the challenge facing policy makers and practitioners interested in establishing paternity for an increasing number of children. In 1989 childbearing among unmarried women reached record levels for the second year in a row. The rate of 41.8 births per 1,000 unmarried women was 8 percent higher than the previous year, and 42 percent higher than 1980. In 1990, 28 percent of children born in the U.S. were born to unmarried women. It is estimated by the Federal Office of Child Support Enforcement that paternity is established in less than one-third of these cases. Although the number of paternities established has increased over time, performance varies widely from state to state and paternity still needs to be established for significant numbers of children.

This paper presents results of the National Survey of Paternity Establishment Practices. Conducted in the summer and fall of 1990, these data are the first to provide a nationally representative picture of how paternity establishment is organized and carried out in localities across the country. The paper also explores whether particular practices and policies are associated with higher rates of paternity establishment.

Data Sources

The National Survey of Paternity Establishment Practices was designed to obtain information for 249 counties in 42 states and the District of Columbia. The sample of selected counties was drawn as part of the cluster sampling design used for the 1988 National Survey of Adolescent Males (Sonenstein, Pleck and Ku, 1989).[1] The sample of counties is weighted when frequencies are reported to make the results representative of counties in the contiguous United States.[2]

The survey used a combination of telephone interviews and mail questionnaires. Semi-structured telephone interviews were conducted with state IV-D directors (or someone they designated) and directors of county or sub-state child support programs. Local level administers then asked to complete a close-ended questionnaire. A wide range of topics were covered including, but not limited to, which local agency or agencies were responsible for carrying out paternity establishment; organizational relationships with the welfare agency, the court, attorneys and other relevant agencies; staffing patterns; referral and intake procedures; techniques used to locate and notify fathers; case flow and case management; genetic testing; and perceived barriers.

The response rates on the survey were uniformly high and varied only slightly by the data collection method used. The completion rates were 100 percent for the state IV-D director's telephone survey, 98 percent for the local-level telephone surveys, and 87 percent for the local-level mail surveys.

Dimensions of Paternity Establishment: Organization and Process

Our qualitative and quantitative analyses of the survey data showed that the organizational setting of paternity establishment and the process used establish paternity were two key dimensions to understanding how the paternity establishment function is implemented in localities across the county.

While the structure of paternity establishment includes a broad range of organizational linkages, the locus of responsibility for IV-D paternity establishment at the local level can be captured by three basic prototypes (Figure 1). In general, they delineate the three most common ways states

[1] Additional data about the demographic characteristics of the counties were added to the data file from the County and City Data Book (u.S. Bureau of the Census, 1988). Non-marital births in each county for 1988 were provided by the National Center for Health Statistics.

[2] The weight is the inverse of each county's probability of selection into the sampling frame. A post-stratification adjustment was done to scale the weights to the known distributions of counties by population density, based on data in the 1988 City-County Data Book. The weights were set to average to 1.

have ensured that aspects of paternity establishment which require legal services are readily available.

- **Human Services Organizational Prototype.** The most common organizational setting is one in which both child support and paternity establishment are carried out by a single local human services, or welfare, agency. Used by just over two-fifths (41 percent) of counties, this prototype is distinguished by the fact that the lead agency carrying out paternity establishment does not have a legal or judicial affiliation--that is, not a court, a prosecuting attorney or an attorney general's office. Cases in need of legal services are handled by in-house child support staff attorneys or contract attorneys housed within the IV-D office.

- **Legal Organizational Prototype**. In approximately one fifth (21 percent) of the counties, both child support and paternity establishment are carried out in a legal organizational setting--usually the Office of the Prosecuting Attorney but sometimes a private attorney.

- **Two-Agency Transfer Organizational Prototype.** A combination of the two prototypes described above is found in the two-agency transfer model. In this organizational structure, the local IV-D provider handles all paternity establishment cases up to the point it is determined that the case will or won't contested. This includes intake and locate activities in addition to notifying the father of the paternity allegation. If the allegation is uncontested, the local child support provider, usually the human service agency, handles all subsequent tasks necessary to establish paternity. If the case is contested, (or if the alleged father fails to respond), it is transferred to a (public or private) legal agency to pursue establishment. Slightly over one-third (36 percent) of counties have adopted this organizational approach.

With respect to the processes used to carry out paternity establishment, our examination of the survey data led us to identify four prototypical paternity establishment processes (Figure 2).[3] The first, found in one-fifth (20 percent) of counties, is a "no-consent process" in which all paternity cases are handled through the court and there are no formal opportunities to consent voluntarily to paternity outside of a court hearing. The other three prototypes are variations of a voluntary consent approach in which paternity acknowledgments can be taken out of court and used to establish paternity. The most common is the "multi-consent process" which is used in over one-third (37 percent) of counties. A one-time consent process is used in one-fifth (20 percent) of all counties. A final prototype, coined the "court-as-last resort process", is found in 16 percent of counties.[4] The basic case flow of paternity cases by the type of process used is described next.

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[3] The paternity establishment process consists of sequential stages, each of which include a variety of steps and practices. The first stage involves initiating the paternity case into the IV-D system and collecting information about the alleged father. The second stage involves locating the alleged father. The third stage involves notifying the father of the paternity allegation. The case then moves into the final adjudication stage, at which point paternity is legally established. This paper limits discussion of the paternity establishment process to the adjudication stage.

No-Consent Process (Figure 3). This process is characterized by a high degree of interaction with and dependency on the court. The alleged father is notified of the paternity allegation and instructed to attend a mandatory court hearing. At this court hearing, he may acknowledge paternity but this does not generally happen in practice. Survey respondents estimated that, on average, only 14 percent of all paternities established are adjudicated at this first court hearing in counties using this process. The primary purpose of this hearing, then, is to explain the allegation and order genetic tests. After genetic testing, a second mandatory court hearing is held at which time the genetic test results are reviewed. This is where the bulk of cases are settled among counties using this process--an estimated three quarters of all paternities are established at this second hearing. As might be expected, given its traditional court-orientation and attendant emphasis on due process, the no-consent prototype does not make great use of default judgments as a method to establish paternity. Only 7 percent of adjudicated paternities were established through default.

Thus, almost all paternity establishment cases in a no-consent process will go through two court hearings and genetic testing before the paternity of a child can be established. Because of its heavy reliance on the court, this prototype is particularly dependent on the court's ability to schedule hearings quickly if the IV-D paternity agency is to move the case forward on a timely basis.

One-Time Consent Process (Figure 4). This process includes one formal opportunity to voluntarily acknowledge paternity out of court, almost always after the alleged father initially receives notification of the paternity allegation. The notification includes a request that the alleged father contact the IV-D paternity agency to set-up or confirm a voluntary consent conference date rather than going through a court hearing. Respondents using this process estimated that 30 percent of cases of their adjudicated paternities were established at this voluntary conference.

If the alleged father attends this conference and consents, appropriate forms are signed and no further involvement on the part of the father (at least with regard to paternity) is necessary in six out of ten (62 percent) counties. In the remaining 40 percent of these counties, fathers who voluntarily acknowledge paternity are still required to appear before the court. This practice appears to be a hold-over from the traditional court process which requires court appearances to ensure that the father is given full due process.

---

[4] The adjudication process did not fit easily into one of these four prototypes in eight percent of the cases.

If the alleged father does not acknowledge paternity at the consent conference, a court date is scheduled in almost two-thirds (62 percent) of counties to order genetic tests. Sixteen percent of counties do not need to hold such a hearing if the father stipulates at the conference that he will undergo genetic testing (16 percent) while another 22 percent of counties simply move directly to genetic tests without a stipulation or court hearing on the matter. A small proportion (11 percent) of these counties also offer the opportunity to stipulate to genetic test results. This type of stipulation means that if the genetic test results yield a certain level of probability that the allegation is true, the father will accept the test results and no further action is required to legally establish paternity.

Another court hearing is held after genetic testing to review the test results. Almost half (49 percent) of paternities are reportedly established at this court hearing. Counties using the one-time consent process also estimated that 12 percent of paternities are established by default. Thus, about half of paternity establishment cases adjudicated in counties using the one-time consent process basically follow the same case flow as found in no-consent process counties--two court hearings and genetic testing. In contrast, however, about one-third (29 percent) of cases are resolved out of court (i.e., at a voluntary consent process) prior to the first court hearing.

Multi-Consent Process (Figure 5). This process offers at least two opportunities for the alleged father to consent voluntarily-- before genetic testing and after genetic testing. Just like the one-time consent process, counties using this multi-consent process notify the alleged father and ask or request that he attend a voluntary consent conference. If he does attend this conference and consents to paternity, no further involvement on the part of the father is necessary in nine out of ten (92 percent) counties. Thus, unlike the one-consent process, only a small proportion (7 percent) of multi-consent counties apparently need to ensure that all fathers who voluntarily acknowledge paternity "have their day in court".

If the alleged father attends the conference but does not acknowledge paternity, almost all (92 percent) of these counties provide an opportunity to avoid a having to go to court to get an order for genetic testing, usually by offering the alleged father a chance to request blood tests.

Unlike the one-time consent approach, this prototype offers a second formal opportunity to voluntarily consent after genetic testing. Over one third (37 percent) of paternities are reportedly established at this second conference.

If, however, the alleged father does not respond or attend this second conference, a court hearing is held to adjudicate paternity. According to respondents, a much smaller proportion of paternities (16 percent) are established at this second hearing. Finally, counties using this process report that, on average, about a tenth (11.5 percent) of their adjudicated paternities are established by default.

Thus, unlike the no-consent and one-time consent processes, the majority of paternities established by counties using a multi-consent process are resolved voluntarily before any formal court action takes place--about one-third prior to genetic testing and another third after genetic testing. These counties are also much more likely to offer stipulations to genetic tests and genetic test results, which also expedites the process. The multi-consent process counties use of defaults to establish paternity is, however, similar to that of the one-time consent process.

Court-as-Last-Resort Process (Figure 6). The court-as-last-resort process earns its name because it is the least dependent of the four prototypes on securing and scheduling court time in order in order to move a case forward through the various steps necessary to establish paternity. Upon notification, the alleged father is directed to file his response to the paternity allegation with the court. If he files he is willing to consent, a conference is scheduled. About a quarter of paternities in counties using this process are reportedly established at this voluntary conference. If, however, the alleged father files a denial he almost always proceeds directly to a genetic testing appointment. Three-quarters (77 percent) never require a court hearing to order genetic tests. Another tenth (9 percent) offer alleged fathers who express uncertainty at the conference the opportunity to stipulate to genetic tests and 7 percent also offer the option to stipulate to genetic test results. Like the multi-consent process, an additional formal opportunity to consent is almost always made available after genetic testing and an average of 30 percent of paternities are established at this conference. If however, the alleged father chooses not to respond or to attend the conference, a court hearing is held and, based on genetic test results, paternity is established. Only 12 percent of paternities are established at this last point.

Respondents estimated, on average, that a little over a quarter of paternity cases in these counties were established by default. This relatively high proportion of default paternity judgments is double the share reported by one-time and multi-consent process counties and quadruple the share reported by no-consent process counties.

Promising Approaches to Paternity Establishment

A regression analysis was conducted in order to explore whether the paternity establishment rates were associated with socioeconomic or programmatic characteristics found at the local level. Four different classes of variables were included in the analysis: (1) the demographic and socioeconomic characteristics of the county: (2) the resources invested in child support services in terms of money and staff; (3) particular combinations of organizational locus and consent opportunities described above; (4) the use of specific policies and procedures identified by the literature as characteristic of exemplary programs.

The number of non-marital births in 1988 in each county was used as the base for calculating standardized county paternity establishment rates.

The analytic approach was essentially exploratory. Ordinary least squares regression techniques were used to establish models of paternity establishment. Table 1 summarizes the results of our multiple regression analysis. The following discussion highlights some of these findings.

Table 1: County Characteristics and Paternity Practices Associated with Paternity Rates (OLS)

Coefficient	
County Demographics	
Unemployment Rate (1986)	-1.307*
Proportion Families Below Poverty (1979)	0.714
Census Region North	0.120*
Census Region South	-0.055
Net Population Change (1980-1986)	-0.518***
Interaction North*Pop.Change	-2.807***
Rural Nonmetropolitan County	0.142**
Urban County, Population < 200,000	0.205***
Urban County, Population 200,000-500,000	0.136**
Resource Investments	
Low AFDC Caseload Per Worker	0.109*
Medium AFDC Caseload Per Worker	0.014
Moderate AFDC Caseload Per Worker	0.103*
CSE Budget/Divorces in County[a]	0.006*
Organizational Approach	
Multiple Consent/Two Agency Transfer	0.372***
Court as Last Resort/Human Service Agency	0.131
Court as Last Resort/Legal Agency	0.104
Other Exemplary Practices	
Crime/School Records Routinely Used for Locate	0.069**
Default Issued for Failure to Respond to 1st Notice	0.096
State Pays Up Front For Genetic Test	0.143**
Father Stipulates to Test Results	0.200***
Quasi-judicial Staff	-0.148***
Computer System Generates Forms	0.058**
System Alerts Worker When Case Action Required	-0.073*
Computer Interface between IV-A and IV-D	-0.105**
CSE Agency is the Same at State & Local Levels	0.142**
(Constant)	0.129
Adjusted R Square	.359

*** $p < .01$ ** $p < .05$ * $p < .10$

[a] Divided by 1,000

Socioeconomic and Demographic Characteristics. We found that paternity establishment rates are significantly associated with socioeconomic and demographic characteristics of the counties. The paternity rate is significantly and negatively associated with the county unemployment rate and the population growth rate. It is positively associated with rural and smaller urban counties in contrast to highly populated urban counties. Thus counties with high unemployment, large population size and high population growth, especially high population growth in the North, show poorer performance on paternity establishment rates than counties without these characteristics.

Program Resources. Holding the demographic and socioeconomic variables constant, we found the performance of counties in the area of paternity establishment is higher in counties with higher child support enforcement program budgets (relative to divorces in the county) and when there are more child support staff relative to the size of the AFDC caseload. County demographics and program investments explained 13.9 percent of the variation in the dependent variable, a 2.4 percent increase over the model with just demographic variables.

Organizational Settings and Voluntary Consent Approaches. Counties with the highest rate of paternity establishment offer multiple opportunities for consent and have adopted the two-agency transfer organizational approach in which voluntary consents are handled by the human service agency and contested cases are transferred to a legal agency. The use of these combined approaches is associated with a 41 percentage point increase in the paternity establishment ratio. The second best approach appears to be combine the court-of-last-resort consent process with locating responsibility for paternity cases in the human service agency. This combination was associated with a 22 percentage point increase in the paternity establishment rate. The variance explained by the model almost doubled, reaching .26 percent, when the combined organizational and consent approaches to the model.

Selected Practices. Some practices also appear to be independently associated with the paternity establishment rate. Counties using criminal record checks and school records show performance levels 7 percentage points higher for each type of record used. Two practices with genetic testing were also associated with higher performance levels. These are the use of stipulations to test results and the practice of states' paying for the genetic tests (rather than requiring the father to do so). Both of these practices are fairly uncommon but stipulations to test results (or using a rebuttable presumption of paternity) is associated with a paternity rate that is 20 percentage points higher than the rate for counties no using this practice. When the state pays for the entire cost of the genetic tests rather than requiring fathers to pay, the paternity rate appears to be 14 percent higher.

Conclusion

The National Survey of Paternity Establishment Practices revealed extensive variation in paternity establishment practices at the local level. The prototypes of how paternity is organized and carried out capture the basic differences in paternity establishment at the local level along two major dimensions. The multi-variate analyses suggest that combinations of these dimensions are associated with differences in the paternity establishment rate and that some combinations appear superior to others.

The multi-variate analyses are exploratory and the findings are merely suggestive of possible avenues to follow in seeking improvements in program performance. Our analysis suggests that there are associations between the presence of certain practices and paternity establishment rates. However, we cannot establish the direction of causality because these are cross-sectional analyses and therefore we have not observed what happens over time before and after a practice is implemented. The regression approach tested the introduction of variables sequentially and in a logical order, but our results could have been different if the variable groupings had been shuffled or entered in a different order.

A major focus on improving paternity establishment performance among IV-D agencies concerns adopting practices that will better streamline and expedite the process. While still exploratory, our analysis does show some evidence that organizational and consent procedures used by counties are associated with different levels of paternity performance as are some practices. Incorporating multiple opportunities for voluntary consent, minimizing dependence on courts and mandatory court hearings to adjudicate paternities, using defaults and stipulations to genetic tests results, and streamlining paternity work through a two-agency approach appear to offer promising possibilities for increasing the proportion of children born outside of marriage for whom paternity is established.

Figure 1
Organizational Responsibility for Paternity Establishment at the Local Level: Three Prototypes
(weighted percentages)

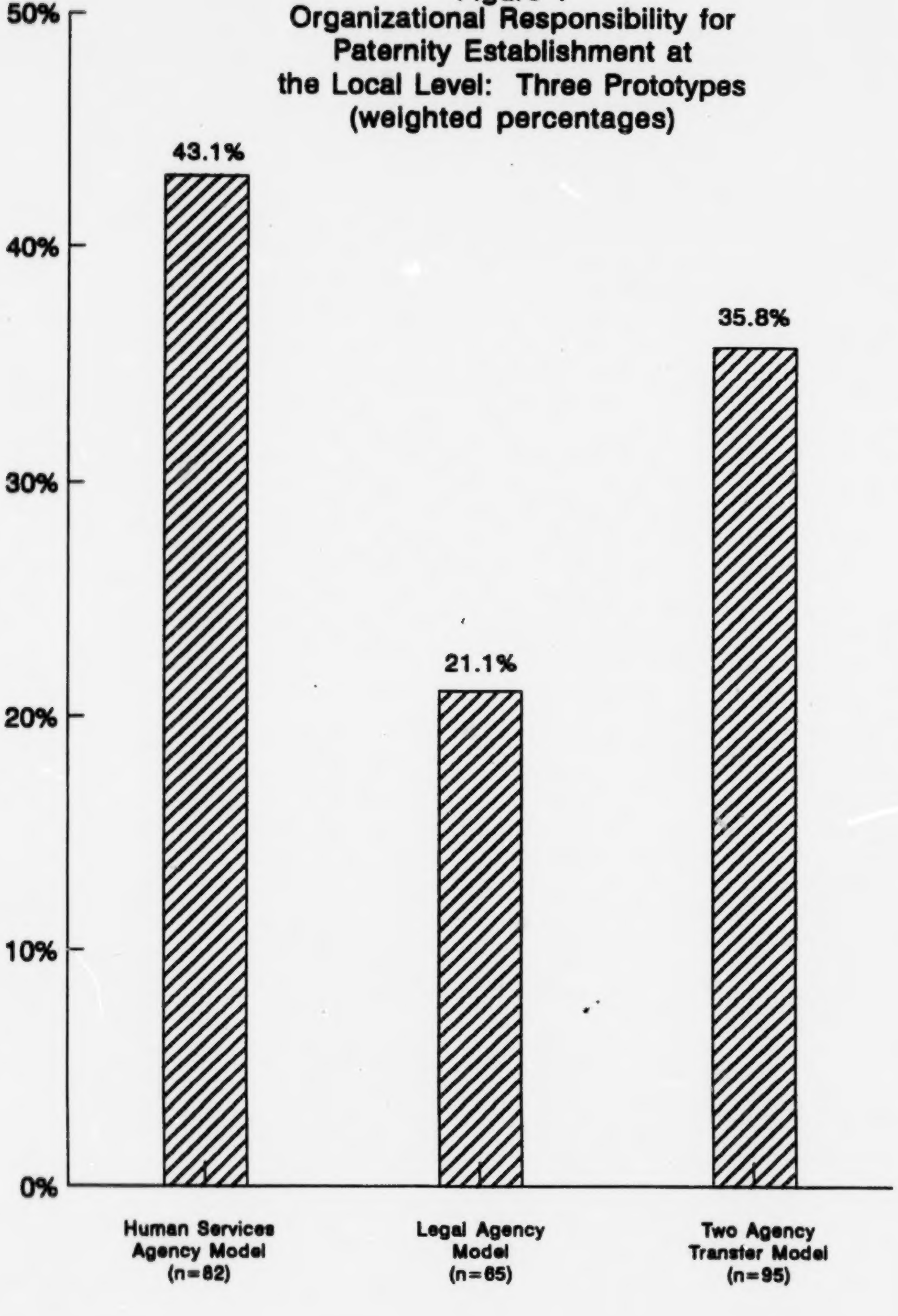


Figure 2
Paternity Establishment Process: Four Prototypes
(weighted percentages)

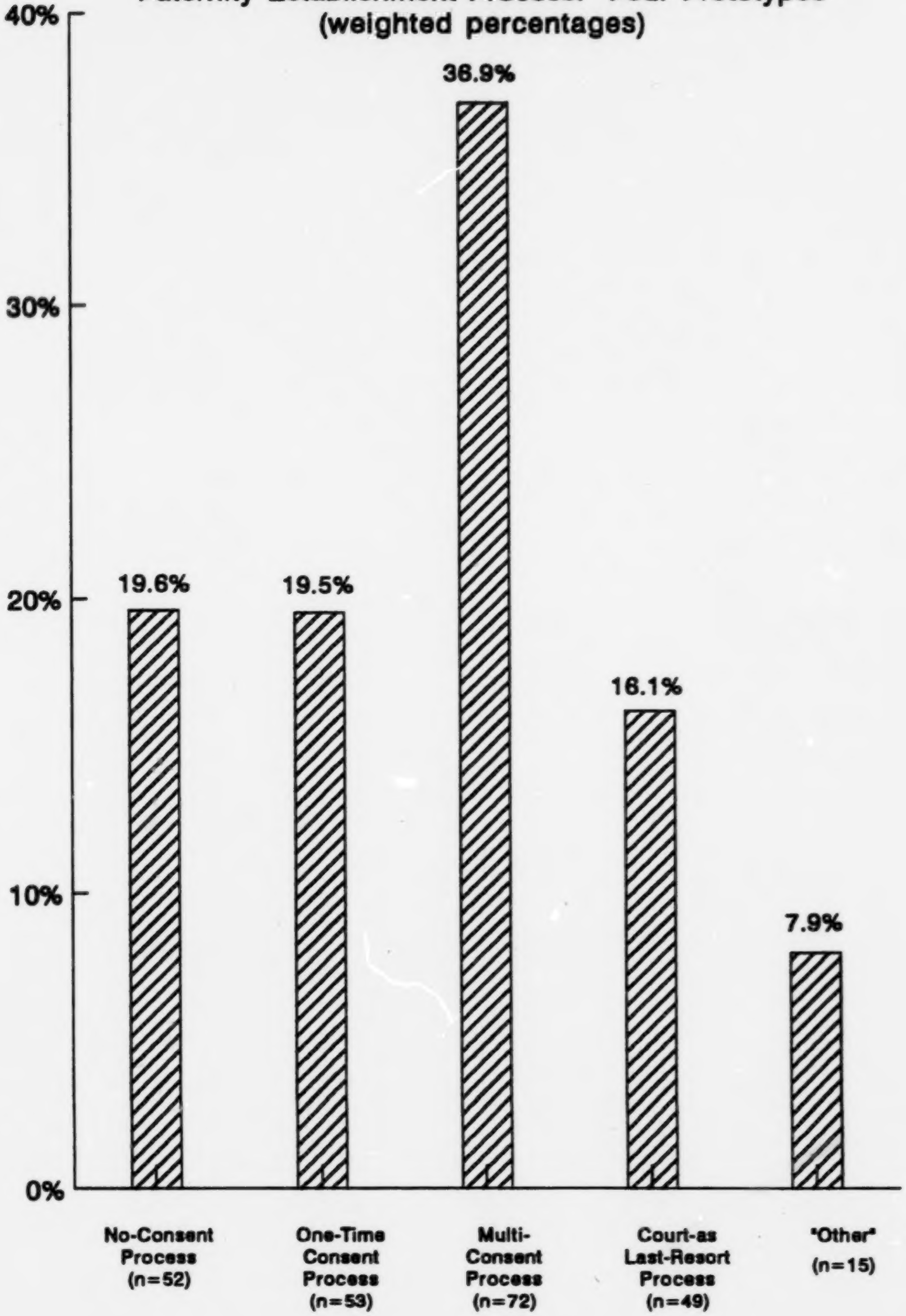


Figure 3
No-Consent Paternity Establishment Process:
Basic Caseflow

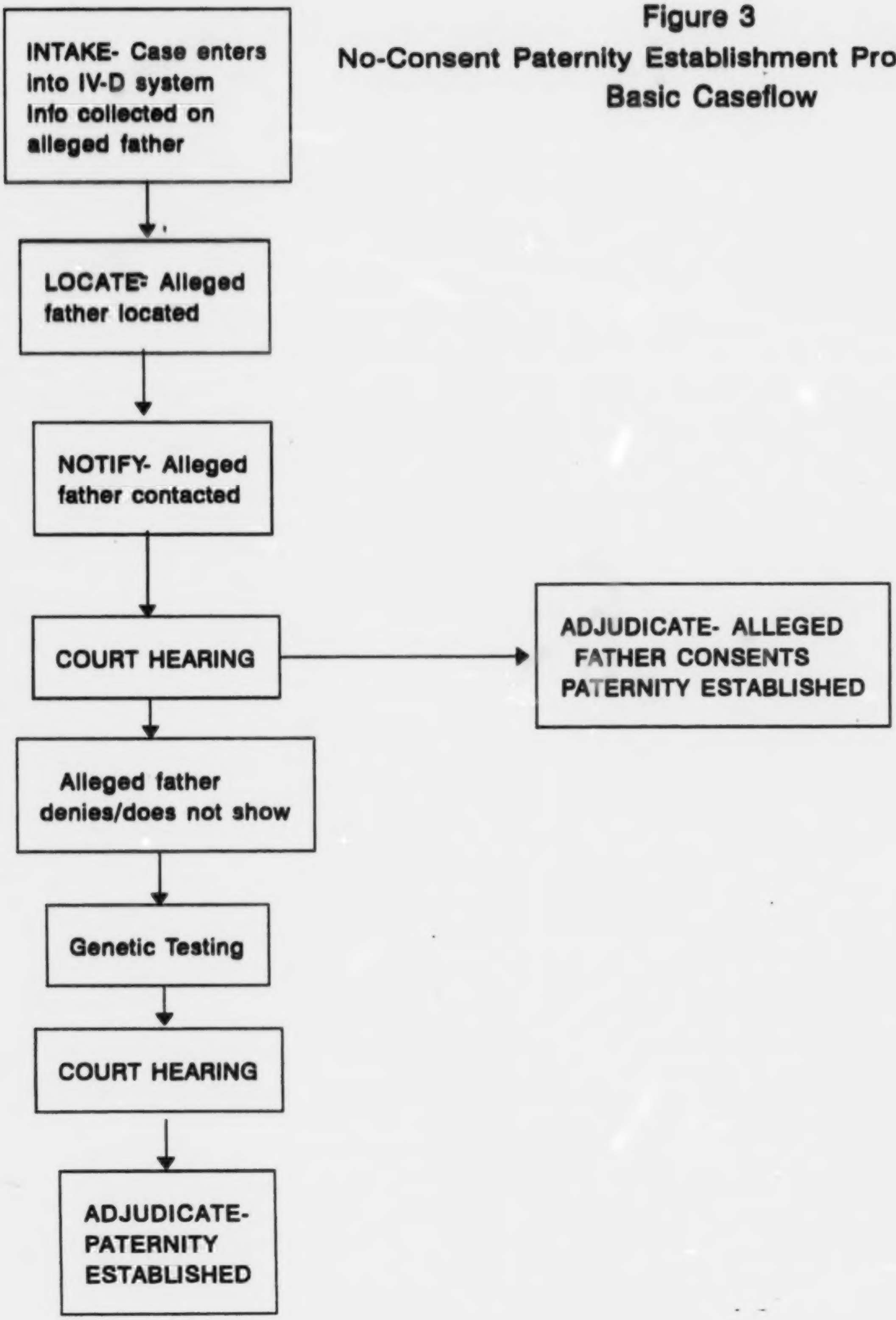

INTAKE- Case enters into IV-D system Info collected on alleged father
LOCATE- Alleged father located
NOTIFY- Alleged father contacted
COURT HEARING
ADJUDICATE- ALLEGED FATHER CONSENTS PATERNITY ESTABLISHED
Alleged father denies/does not show
Genetic Testing
COURT HEARING
ADJUDICATE- PATERNITY ESTABLISHED

Figure 4
One-Time Consent Paternity Establishment Process: Basic Caseflow

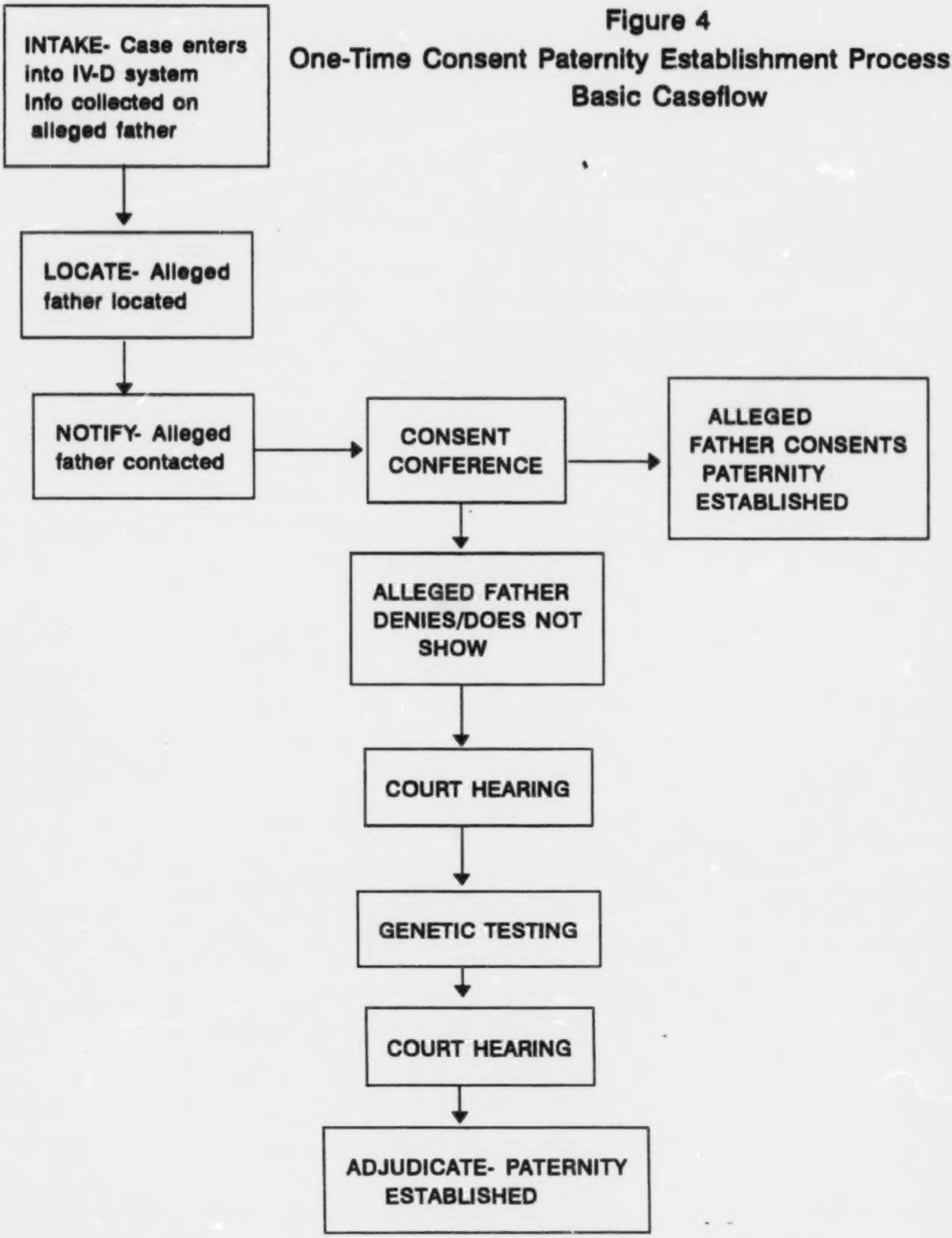

INTAKE- Case enters into IV-D system Info collected on alleged father
LOCATE- Alleged father located
NOTIFY- Alleged father contacted
CONSENT CONFERENCE
ALLEGED FATHER CONSENTS PATERNITY ESTABLISHED
ALLEGED FATHER DENIES/DOES NOT SHOW
COURT HEARING
GENETIC TESTING
COURT HEARING
ADJUDICATE- PATERNITY ESTABLISHED

Figure 5
Multi-Consent Paternity Establishment Process
Basic Caseflow

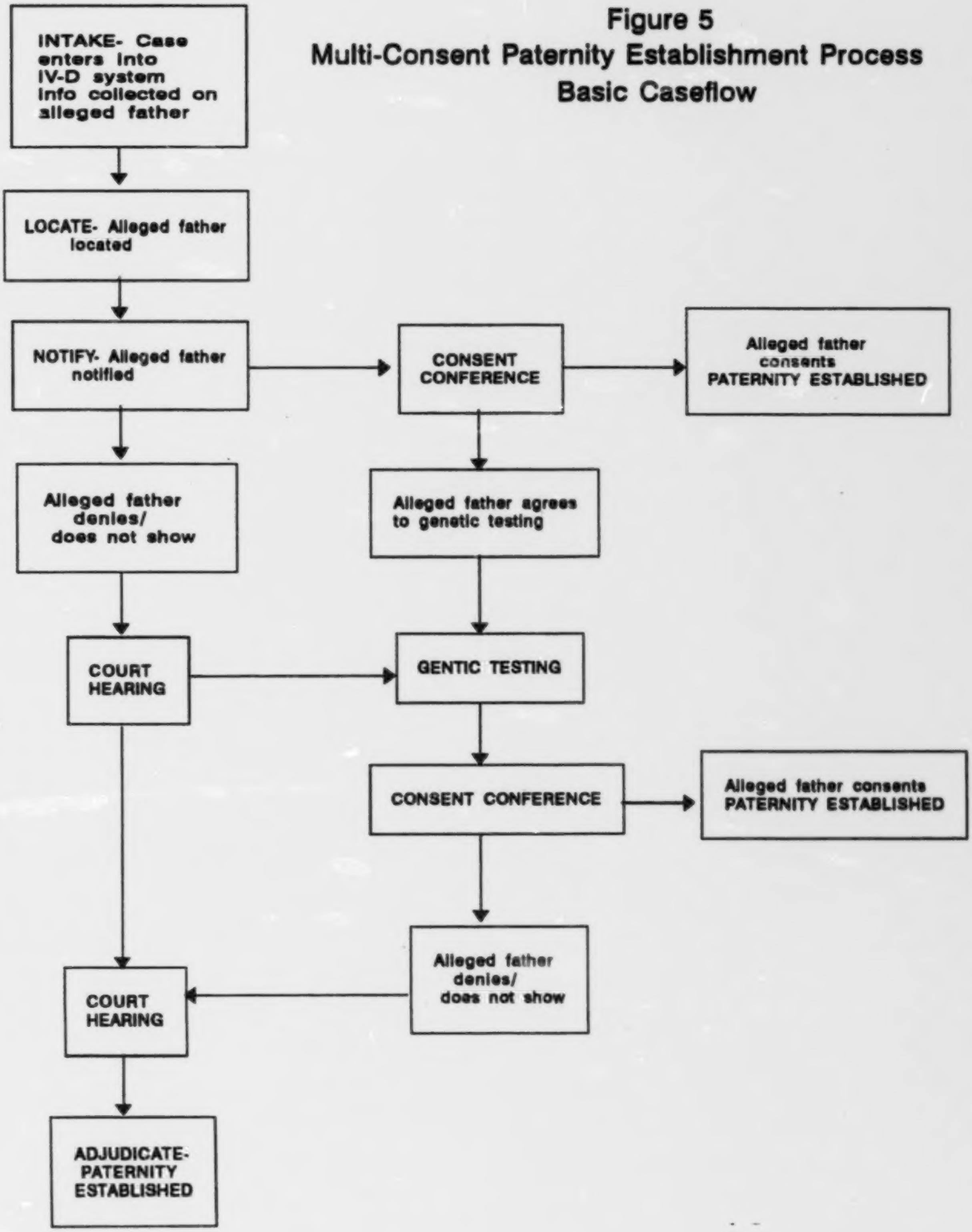
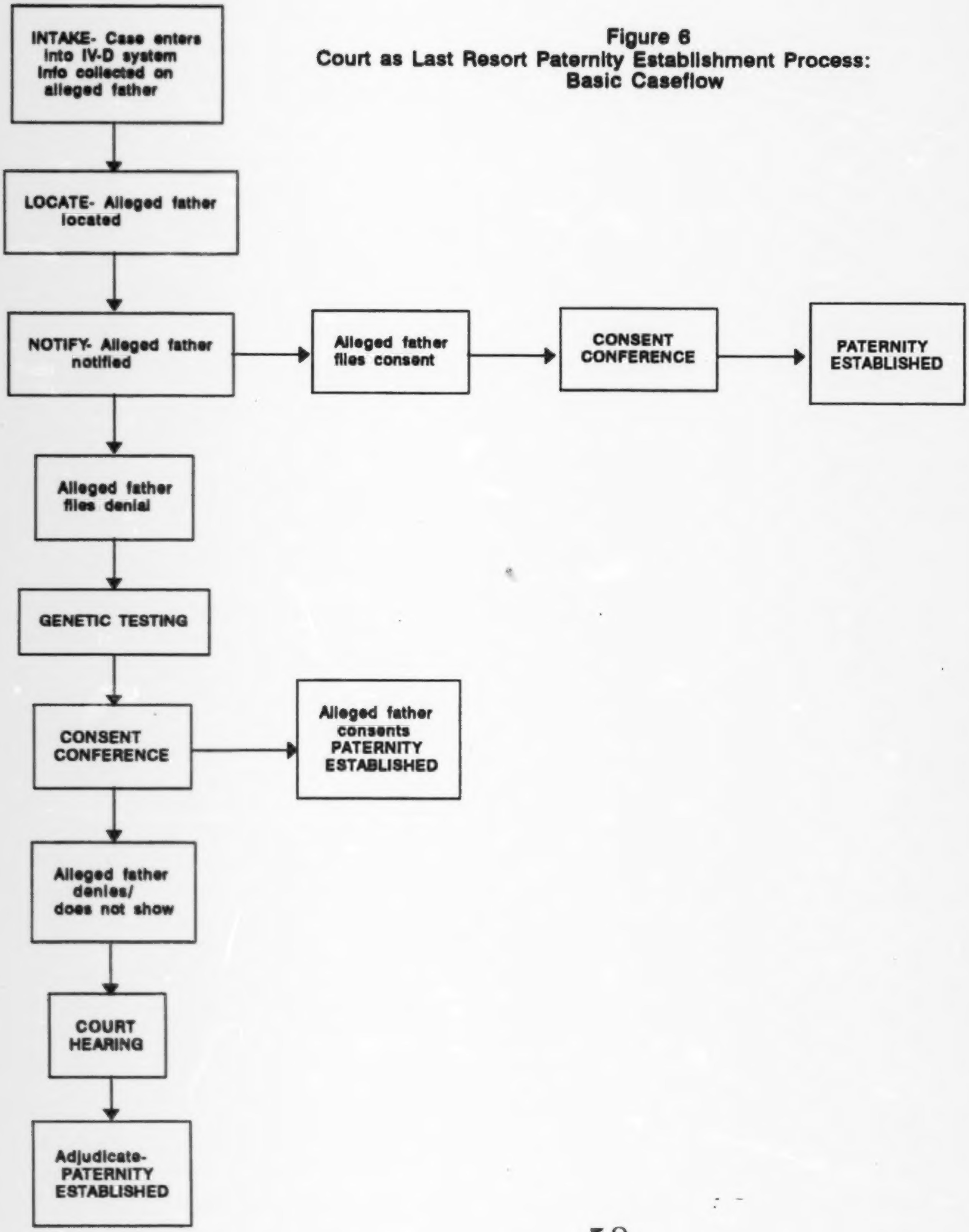

INTAKE- Case enters into IV-D system info collected on alleged father
LOCATE- Alleged father located
NOTIFY- Alleged father notified
CONSENT CONFERENCE
Alleged father consents PATERNITY ESTABLISHED
Alleged father denies/ does not show
Alleged father agrees to genetic testing
COURT HEARING
GENTIC TESTING
CONSENT CONFERENCE
Alleged father consents PATERNITY ESTABLISHED
Alleged father denies/ does not show
COURT HEARING
ADJUDICATE- PATERNITY ESTABLISHED

Figure 6
Court as Last Resort Paternity Establishment Process:
Basic Caseflow


INTAKE- Case enters into IV-D system info collected on alleged father
LOCATE- Alleged father located
NOTIFY- Alleged father notified
Alleged father files consent
CONSENT CONFERENCE
PATERNITY ESTABLISHED
Alleged father files denial
GENETIC TESTING
CONSENT CONFERENCE
Alleged father consents PATERNITY ESTABLISHED
Alleged father denies/ does not show
COURT HEARING
Adjudicate- PATERNITY ESTABLISHED

Federal Regulation Update and Description of Current Trends in Paternity Establishment

Jean Irlbeck, J.D., Paternity Establishment Associates, Inc.

This presentation provided an update on federal regulations and a description of current trends in paternity establishment. Some of the model programs by states were highlighted.

Case Management and Community-Based Care

Moderated by Michael Theis
Virginia Department of Social Services

Evaluation of Case Management in Community-Based Long Term Care in Delaware's Department of Health and Human Services: Divisions of Aging and Social Services - Celeste Anderson, Delaware Health and Social Services

Managing JOBS Caseloads - Gary Silverstein, Institute for Family Self-Sufficiency, American Public Welfare Association

Services to Runaways and At-Risk Youth - Sue E. Calland, Texas Department of Child Protective Services

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Case Management and Community-Based Care

Evaluation of Case Management in Community-Based Long Term Care in Delaware's Department of Health and Social Services: Divisions of Aging and Social Services

Celeste Anderson, Delaware Department of Health and Social Services

Background

In the Department of Health and Social Services (DHSS), three different programs provide community-based services to elderly and physically disabled people: the Comprehensive Client Assistance Program (CCAP) in the Division of Aging, the Social Services Block Grant Program for disabled clients aged 18-59 (SSBG 18 - 59) in the Division of Social Services/Medicaid Unit, and the Home and Community-Based Services Waiver, also in the Division of Social Services/Medicaid.

An evaluation of case management in the three programs was requested by the Long Term Care Oversight Committee, a group of DHSS staff, community agencies, service providers, and consumers. The purpose was to describe the structure of the current system and to examine the differences and the similarities between the programs. The overall question was: Does community-based Long Term Care (LTC) achieve the department goal of being a client-oriented, rather than a bureaucratic, structure?

In a chapter on a Colorado Day Care program, in Community-Based Long Term Care: Innovative Models, the author describes the problems faced by planners of such systems and by clients seeking community-based services.

> Attempts to develop noninstitutional, community-based long-term care alternatives have met with limited success. Many efforts have been criticized for having neither the level of funding nor the level of coordination necessary to serve those with the greatest need. Public policy makers must maintain the balance of resource allocation and cost control...Individuals seeking to use the options currently available in long-term care encounter a system that is fragmented, complex, competitive, and inaccessible.[1]

A client-oriented approach would seek to reduce the problems of fragmentation, complexity, competitiveness, and inaccessibility.

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[1] Barley, Linda S., Community-Based Long-Term Care: Innovative Models, edited by Judith Ann Miller, page 219.

Methodology

Evaluation Questions

Specific questions for the evaluation were:

1) Are there two types of case management in the LTC system? Is it appropriate for both DoA and DSS to be doing case management? Does it make sense for two separate groups in the LTC section of Medicaid to be doing case management?

2) How do clients enter the LTC system? What are the obstacles they face in navigating the system? Is there coordination between the Divisions and programs and between the Divisions and the provider agencies?

3) What are the gaps in services?

Methods

The evaluator reviewed program literature and other literature about long term care case management; abstracted data from a random sample of 55 cases and observed each aspect of case management in both agencies: from intake through enrollment of clients and acceptance of the care plan. With Medicaid, observation included home visits with a Pre-Admission Screening social worker and nurse team, an office visit with a client and a Financial Eligibility worker, and home visits with a HCBS Waiver case manager and a nurse consultant. The evaluator also accompanied the Medicaid SSBG (18 - 59) case manager on home visits. Aging's intake process and home visits with two CCAP case managers were observed.

To obtain the input of knowledgeable people outside the Department and the perspectives of clients, interviews with contractor agencies and advocate groups were conducted.

Limitations of the evaluation

Before this evaluation began, the plan was to use a team of evaluators. However, in restructuring the administration of DHSS, two members of the team were deployed to other positions. Therefore, parts of the original design had to be altered. Specifically, only a small sample of randomly selected records (and only New Castle County) could be reviewed. When possible, findings were compared to findings in other reports.

The client survey was eliminated due to lack of staff and resources to conduct it; therefore questions about the coordination of services and the problems clients face navigating the system were added to the contractors' interviews. One of the recommendations of the report was to survey a randomly selected, statistically valid sample of community based LTC clients on their satisfaction with processes and services. Furthermore, the LTC Oversight committee conducted statewide consumer focus groups.

Findings

1) **Is it appropriate for both the Division of Aging and the LTC section of Medicaid to be doing case management? Are there two types of case management in the LTC system.**

To answer this question, the similarities and differences in case management in the Divisions and programs were examined. **Similarities were found in the Divisions' definition of case management, job descriptions and training of case managers, caseloads, and funding streams:**

1) Divisions' definition of case management. Case management is central to each of the programs. Its activities are the same: screening for eligibility, intake and assessment, development of a care plan that is acceptable to the client, locating and providing services, monitoring the services, and periodically re-assessing the appropriateness of the services. However, as illustrated below, the processes and emphasis of these activities are different.

2) Job descriptions for case managers. Job specifications are the same for case managers whether they are in Aging or DSS.

3) Caseloads. In New Castle County, caseloads appear to be similar between the programs: 68 - 75 for the SSBG 18 - 59 case manager; an average of 63 for CCAP case managers; and an average of 66 clients for the Waiver. However, comparing caseloads between the Waiver and SSBG/CCAP programs can be misleading. The Waiver program has many more requirements from the Federal government. Waiver case managers are also involved with clients who have pending applications; these clients are not counted in the caseload.

4) Overlapping funding streams. LTC case management is funded by Title III and the Social Services Block Grant for clients of the Division of Aging; in DSS, by Title XIX for the Waiver and the Social Services Block Grant for clients aged 18 - 59.

In 1989, SSBG funds were divided between Aging and Medicaid when SSBG clients 60 and over who had previously been served through Medicaid were transferred to the Division of Aging. The funding split was roughly based on the number of clients over and under the age of 60 in the homemaker and adult foster care programs. The number of clients in the 18 - 59 SSBG program has increased since the transfer of the 60 plus population. However, some years funds have been left over and these funds have been shifted to other DSS programs, such as child day care.

Differences between the Divisions, however, exist in the way case management is practiced:

1) Eligibility criteria.

2) Intake and assessment procedures and length of time it takes to obtain services.

3) Number of contacts between case managers and clients.

4) Number of referrals to programs and services outside the menu of services.

5) Costing-out of care plans and actually costs.

6) Services and role of case manager.

The chart below summarizes these differences.

Issue	CCAP	SSBG (18-59)	Medicaid Waiver
Eligibility criteria	flexible	flexible	inflexible
Time to obtain services	2 - 3 weeks	1 or more weeks	3 or more months
# of contacts between case manager and client	more frequent	less frequent	more frequent
Outside referrals	more frequent	less frequent	less frequent
Costing out of care plans	informal	informal	formal
Average cost of care plans	$399 per month	$244 per month	$1,092 per month
Services and role of case manager	hands-on provider of services and coordinator of community resources	broker of purchased services	broker of purchased services

1. Eligibility criteria

The following chart summarizes the difference in eligibility requirements.

Funding Source	Medically Elig?	Income	Assets	Other	Financial Verification?
Medicaid Waiver	Yes (SNF/ICF)	<210% SSI	$\leq$\$2,000	No	Required
SSBG (Aging & Medicaid)	No[2]	<210% SSI	$\leq$\$2,000	No	Not required[3]
Title III (Aging)	No[2]			Age 60 or more	Not required[3]

HCBS Waiver. To be eligible for the HCBS Waiver, potential clients must qualify for admission to a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF) and be financially eligible. As of January 1992, a client was financially eligible for the Waiver if his or her income was less than 210% of the State Supplemental Insurance and assets were $2,000 or less, excluding a $1,500 burial policy. Adjustments are made depending on the size of the household or if the client lives in his/her own home or is responsible for a spouse and/or children.

SSBG. For SSBG clients in both the Division of Aging and Medicaid, the income criteria for homemaker services is the same as for the Medicaid Waiver. To be eligible for adult foster care a client must have a total monthly income of less than $582.00, Social Security Disability or S.S.I. plus the State Supplement and no more than $2,000 in resources. According to David Loughery, SSBG Administrator, the resource limit was part of a policy carried over from the eligibility for Medicaid services. "A few years ago we increased the eligibility level to 210% of SSI to make the SSBG level consistent with the Medicaid Waiver." However, the method by which resources varied between the Divisions. Karen Michel, CCAP Administrator in the Division of Aging, explains: "The SSBG does not require the level of verification that is required by the Medicaid Waiver. Neither SSBG in DSS nor Aging verifies resources at the same level as required by Medicaid for the Waiver... Our policy now specifies that the case manager verify income and liquid resources, i.e. bank accounts, CD's, money markets, etc."

[2] It is policy to target SSBG and Title III funds to persons with the greatest needs; however, these needs may not be medical. There are no formal Federal requirements for medical eligibility, such as those required by the Waiver.

[3] Verification of financial information is not required by the funding source, although it may be required by a Division's own policy.

Title III. Clients are eligible for Title III services on the basis of age (60 years and older). However, the Older Americans Act targets low income and minorities; individual request for services are prioritized on the basis of a combination of assets, type of service needed, and severity of need.

The flexibility of eligibility determination and less stringent verification procedures allows the CCAP and the SSBG (18 - 59) programs to deal with crises and deliver services with dispatch.

2. Intake, assessment, and length of time to obtain services

CCAP and SSBG (18 - 59). Due to the different eligibility requirements between the programs, the process for opening cases in the SSBG (18 - 59) and CCAP programs are similar and much simpler than the process for opening a client in the Waiver. Below is a outline of the steps involved.

SSBG (18 - 59)/CCAP

1. Case is referred to Intake.
2. Case is forwarded to supervisor.
3. Supervisor assigns case to case manager.
4. Case manager makes a home visit, does an assessment of needs and eligibility.
5. Case manager develops a Plan of Care (POC) with client.
6. Case manager opens case and sets up services.
7. Client begins receiving services.

Between intake (Step 1) and the time services started (Step 7) the average is 22.2 calendar days.[4]

For the SSBG (18 - 59), the times are similar. In the sample reviewed for this evaluation, the average length of time between intake and opening the case was 7.3 calendar days.

Waiver program. The steps for getting a client onto the Waiver are more complex and timeliness, to some degree, depends on actions on the part of the client and other persons outside the Department, such as physicians, banks, etc. The following indicates how the case proceeds if a client meets all the eligibility criteria.

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[4] Caution should be used in interpreting results based on the small sample; however, they are confirmed by Aging's MIS reports.

Medicaid Waiver

1. After PAS receives a referral, PAS conducts a home visit to assess the client and to determine if eligible for nursing home placement. Within three days, PAS refers the case to the Financial Eligibility Unit.

    1.a. Client receives a Level II screening if mental illness, mental retardation, or developmental delay are suspected. These assessments are performed by consultants. PAS reviews the Level II screening and forwards it to the Financial Eligibility Unit.

2. Client's physician completes certifying documentation (MAP-25) which PAS reviews and sends to the Financial Eligibility Unit.

3. PAS determines the clients's Level of Care (LOC) and develops a temporary package of care.[5]

4. The Financial Unit reviews the application and supporting verification of assets submitted by the client.

5. The Financial Unit interviews the client and/or the client's representative and asks for additional documentation, if necessary.

6. When all documentation on assets and income are received, the Unit verifies the information and the application is approved.

7. The Financial Unit forwards the case to the Waiver program where a supervisor assigns the case to a case manager.

8. The Waiver case manager makes the initial home visit to explain the program and do an initial assessment.

9. A Waiver nurse consultant makes a home visit.

10. The Waiver case manager develops a POC with input from the nurse consultant, the client, client's family, and other service providers if they are already serving the client. She/he determines that the cost of the plan does not exceed the cost of placement in a nursing home.

11. The POC is approved by the supervisor.

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[5] A memo dated October 13, 1992 from Medicaid to Linda Barnett, states that a temporary care plan may include "SSBG services (DSS and DoA), calling the applicant's physician to get orders for Medicare home health services, community mental health, DMR, making referrals to SSI, CCAP, etc."

12. The case manager reviews the POC with the client and obtains the client's approval.

    12.a. If the client wants changes in the POC, the case manager revises the POC and reviews with the supervisor.

13. Case is opened and case manager sets up services.

In the sample of records reviewed for this study, the average length of time between PAS's visit (Step 1) and when the Waiver case manager opened a case (Step 13) was 215 calendar days. Again, these figures are based on a very small sample; however, they are confirmed by another study which found that for 88 randomly sampled cases, beginning January, 1991, the average time between the date PAS received a referral and the date a case opened was 147 days. This figure included clients who entered nursing homes. Of the 88 clients, 12 entered the Waiver and the total length of time for processing those cases was 216 days.

However, the length of time to obtain services has been recently reduced. According to a Medicaid report for the year July 1, 1991 - June 30, 1992, the average time between steps 1 and 6 was three months. This is due to a recently implemented Medicaid procedure. If the Medicaid Unit decides that the applicant or caregiver is not cooperating with the application procedure, for example, by not completing paperwork, Medicaid closes the case. Medicaid reports that they allow extensions for extenuating circumstances and that a supervisor can allow a worker to help the applicant obtain documentation in special circumstances. However, the latter option is rarely used.

There is a Federal requirement that states must determine financial eligibility for Medicaid for persons with disabilities within 90 days; if not, a state is out of compliance and penalties can ensue. However, when a state cannot make a determination because an applicant or a physician has not submitted documents, it will not be sanctioned, if there is documentation that reminders were sent or other efforts to obtain compliance were made. A state may grant an extension for extenuating circumstances; but neither the circumstances or the length of time for the extension is spelled out in Federal regulations.

While the 90-day deadline may stimulate some clients and caregivers to be timely in the application process, closing cases artificially improves the statistics that are reported. For clients who are very infirm, have cognitive deficits, are homebound and have no assistance to complete and gather the necessary papers, the total time it takes them to get the Waiver may be longer than before, if they have to re-apply. A better measure of how well the system serves the client is the total length of time it takes from initial contact until the client actually receives services.

Medicaid plans to implement other procedures in the near future, such as obtaining State and Federal income tax returns and credit bureau reports, which will speed up the financial verification process and may help clients who have difficulty gathering necessary information.

3. Number of contacts between case managers and clients

In the **Waiver** and **CCAP** samples, the average number of telephone contacts was 14.9 and 22.2[6], respectively. The average number of visits was 3.38 for the Waiver and 3.0 for CCAP. (Waiver figures do not include the number of client contacts by the nurse consultants, so that they underestimate the total number of contacts that Waiver staff have with clients.) CCAP case managers also transported clients - for example to shop for a special item ordered by a physician, to obtain social security benefits, or to take clients to see a nursing home or day care program.

In the **SSBG** (18 - 59) sample, the average number of telephone contacts between the client and the case manager or made by the case manager on the client's behalf was 4.38. The average number of face-to-face visits was 1.38.

Again, these statistics are based on a small sample, so they should be interpreted with caution; however, based on the review of these 55 records, it appears that there is more telephone and face-to-face contact between case managers and clients in the Waiver and CCAP programs than in the SSBG (18 - 59) program.

4. Number and types of outside referrals

CCAP. In the sample of records and the observed home visits, clients were referred to services outside the regular menu, such as: Adult Protective Services, Pre-admission Screening, nursing homes and assisted living facilities, Medicaid Waiver, Food Stamps, Medicaid for health insurance, SSI, General Assistance, physicians, home energy assistance, low income housing for the elderly, group homes, visiting nurses, and financial management services.

SSBG (18 - 59). In the sample of records and observed home visits, the SSBG case manager in New Castle County made discussed the benefits of the Medicaid AIDS Waiver and tried to obtain beds for one of the clients.

HCBS Waiver. Case managers (and nurse consultants) in the sample of Waiver cases and home visits made referrals a senior center after a client expressed dissatisfaction with adult day care, "talking books" for a visually impaired client, counseling at a client's church for problems stemming from a client's separation, and the Financial Unit when a client was considering part-time employment.

Case management in the Waiver tends to focus on the specific services purchased rather than other community resources. This is not necessarily inappropriate, since by the time clients enter the Waiver program, they already have Medicaid and other entitlements, either through case management they received while clients of other agencies or in the process of getting on the Waiver. Under the terms of the Waiver, any available alternate resource should be used before Medicaid services are utilized in order to make the program cost-effective. However, for clients who have not gone through other agencies, there may be gaps in services.

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[6] Figures for CCAP exclude cases which were opened and closed immediately because there were no available services.

During the eligibility determination process, PAS will try to resolve immediate critical needs of clients, such as safety issues; however, the temporary care plans developed by PAS are not the equivalent of a comprehensive care plan. Gaps in service may also result from unavailability of services and the lack of funding to purchase services.

5. Costs

A major difference between the programs in DSS (Waiver and SSBG program for clients 18 - 59) and CCAP is the way that Medicaid case managers track the costs associated with their cases. Aging case managers do not formally cost out their case in terms of services or time spent with the clients. Thus it was more difficult to compute the cost of CCAP cases for the evaluation. However, Aging's LTC MIS has a field for case managers to record their time and reports on individual client costs can be generated.

Since some CCAP and a few SSBG 18 - 59 program clients have regular Medicaid, the cost of their care plans to the state is further underestimated.

6. Services provided and role of case manager

Medicaid Waiver. The Medicaid HCBS Waiver supplies case management, homemaker services[7] (up to 28 hours per week), adult day care, respite care, emergency response system, and medical equipment and supplies up to the monthly cost of nursing home care. The Waiver also includes monitoring of the clients in their homes by nurse consultants on a regular basis (at least once every 60 days for clients who qualify at the ICF level of care and every 30 days for clients at the SNF level of care.) Clients also receive services that Medicaid will pay for such as medicines, home health aides, visiting nurses.

SSBG for clients 18 - 59. The SSBG program in Medicaid offers: homemaker, adult foster care, Meals on Wheels[8], respite and adult day care to clients 18 - 59 years of age. The latter two services are offered very infrequently to SSBG clients. Clients tend to get either homemaker or Meals on Wheels. Available service slots are very limited.

[7] Throughout this report, the term homemaker services includes personal care as well as other activities, such as light housekeeping.

[8] To be eligible for Meals on Wheels under the SSBG 18 - 59 program, a physician must certify that the program is medically necessary for the client. The Meals on Wheels program for the 18 - 59 population is more financially limited that for those aged 60 and over.

In both DSS programs, the services which are available to clients with disabilities are identical to those offered to elderly clients. There is little flexibility in providing services which clients might need, such as providing microwave ovens so that clients could easily prepare their own meals, paying to make physical modifications to the homes, and attendant services in place of homemaker services. It should be noted that while homemaker services and attendant services both include personal care, attendant services have a different focus. Attendant services emphasize consumer control and may be delivered in the home, at work or while traveling.

CCAP. CCAP provides homemaker services, adult day care programs, respite care, and adult foster care. In addition, clients are referred to telephone reassurance program, home repairs, home weatherization, home energy assistance, and other programs external to the Division and the Department. CCAP accesses more "other" services (outside the services they directly provide) for clients than Medicaid. CCAP case managers also provide more services directly such as picking up prescriptions, helping illiterate clients with paying bills and reading them their mail.

Aging has a limited fund for client emergencies which case managers can access by request through the case manager supervisor. This fund can be used for housing, food, paying utilities, and clothing, when other resources are not available or have been exhausted. Case managers in Medicaid do not have access to such a fund.

Another difference between Aging and Medicaid is the Meals on Wheels program. Meals on Wheels for the 60+ population are provided through Title III funds, unlike Medicaid which has only SSBG funds to purchase Meals on Wheels. In Aging, the problem with MOW's is a scarcity of providers. The limitation on MOW's for the 18 - 59 year old population is partly due to lack of funds and partly because of the provider's capacity.

2) How do clients enter the LTC system? Is there coordination between the Divisions? What problems do clients face navigating the system? Is there coordination between the Divisions and the provider agencies?

There is no single point of entry for an elderly person or someone with disabilities who desires community-based LTC. Elderly persons may be referred to CCAP on the basis of age or to the Waiver on the basis of disability or to both programs. Non-elderly clients with disabilities may be referred to the SSBG (18 - 59) or the Waiver, depending on their level of need.

Clients may enter the programs through self-referral, referrals from hospitals, neighbors, other social service agencies, such as a State Service Center, or a service provider who serves a client through Medicare, or from a nursing home.

As clients' needs change, they sometimes move between programs. A client may enter the SSBG program from the Waiver. Or an SSBG 18- 59 client will be transferred to CCAP upon reaching the age of 60 and get a new case manager and often an entirely new set of care providers.

It is not always clear to people trying to access the system which Division should serve the client. In these cases, the lack of a single point of entry and a standardized method of assessment may add unnecessary delays or obstacles. Coordination between Aging and DSS is informal, without systematic tracking of clients as they move between the two agencies.

Provider agencies sometimes enhance coordination by making simultaneous referrals to Aging for CCAP and DSS for the Waiver. This is only possible when a client is nursing home eligible and 60 or older. Clients obtaining services through CCAP while their Waiver application is being processed receive more paid and hands-on services than clients who are under the age of 60.)

Referral practices among providers

Interviews with staff of provider agencies that refer or receive referrals from the Waiver, SSBG 18 - 59, and CCAP indicated that there was wide variation in the number of clients referred by the different agencies and the number of clients in the programs. One case manager who had worked for over 14 years in a provider agency had made no referrals to the Waiver in the past because she was unaware of the program. (The Waiver first began providing services on February 24, 1987.) She learned of the Waiver through the parent of a client who had come to their agency. The agency is now in the process of reviewing their client records to see who might qualify for the Waiver.

Case managers at an agency which has a large proportion of young clients with disabilities stated that they do not refer to the Waiver except in special cases. For example, they referred a client who had just obtained SSDI and was not eligible for Medicare for 2 years. According to one of the persons interviewed, "Regular Medicaid covers about as much. Frankly, we see no benefit beyond the emergency response system that the Waiver provides. Our clients need services right away and being on a waiting list does not benefit them."

3) What are the gaps in services?

Interviews with case managers and administrators at provider agencies that work with both Medicaid and the Division of Aging identified certain gaps and unmet needs.

- More could be done for younger persons with disabilities. One of the major impediments to enabling a disabled person to live in the community was the lack of attendant care and alternative living situations. "There are about 200 non-MR disabled adults who would benefit from attendant independent living."

- Adult day care, as it exists in Delaware, was not seen as an attractive alternative for young clients with disabilities who are not mentally retarded.

- Medicaid coverage for medical equipment was identified as a continuing problem. The coverage was thought to be insufficient for wheelchairs and communication devices, among others. Certain other supplies, such as communication devices and special bathing devices Medicaid does not consider "medically necessary", even though prescribed by a physician.

◆ One case manager at an agency noted that a couple of the clients she had referred were financially ineligible for the Waiver because they had trust funds from court settlements; therefore their assets were too high. She felt that since these trusts were to cover the person's needs for life, these assets should be counted in a different way. Delaware Medicaid response is that it is "mandated by the Federal government to follow the eligibility rules specified in its State Plan."

◆ Transportation to pick up medications and to physician's appointments is a problem for many elderly clients and clients with disabilities.

◆ While one provider agency felt that elderly clients were more likely to be socially isolated, staff at another agency which deals primarily with younger clients with disabilities contradicted this belief. They gave examples of persons with severe disabilities in their 50's, especially in rural parts of the state, who were cared for by their parents at home. Some of these people had never received schooling or had any contact in their communities. When their parents become unable to care for them through age or death, they are entirely without other resources.

Conclusions and Recommendations

Recommendation 1 is the major recommendation and could be achieved by restructuring all community-based DSS and Aging LTC programs into a single Division or unit. A common intake system for programs in both Divisions might serve the same purpose, and be easier to implement.
Recommendations #4, 7, 8, and 16 could be considered intermediate steps towards a single Division or unit, but should also be implemented independent of that process to improve coordination. Recommendations #2, 3, 5, 6, 9, 11, 13, 14 and 15 should be implemented with all due speed, whether or not restructuring occurs because they will enhance the services for clients. Recommendations 10 and 12 pertain exclusively to DSS/Medicaid.

As it exists, the LTC system is structured to fit funding streams and eligibility criteria, rather than client needs. Since there is no single point of entry, clients may not be directly referred to the appropriate source.

Clients over the age of sixty, who may be eligible for the Waiver, are best served by the system if they are referred to the Division of Aging and the HCBS Waiver at the same time because CCAP acts as a "safety net." Clients under 60 do not have the same "safety net" that the elderly do.

Recommendation 1: Ultimately, the system should be restructured so there is a single point of entry for any elderly person or person with disabilities. It is difficult for clients or potential clients to understand the way the programs relate to one another. Clients may move from one program to another, but not understand that they will no longer be getting services from the former program.

Recommendation 2: A standardized summary of the Departmental LTC programs should be prepared explaining the eligibility criteria of each of the programs, the services available and the names and telephone numbers of contact persons. Because of the number of people with whom they may come in contact, clients are not always clear about who is serving them and what the services are that they are getting.

Recommendation 3: Clients should be given a copy of their care plan with the name and telephone numbers of the case manager, the nurse (if applicable), and the providers who will be performing the services. There is no formal means of tracking referrals between agencies.

Recommendation 4: Improved coordination and communication are needed between the case managers in Aging and Medicaid through: a) consistent tracking of inter-Divisional referrals, especially between Medicaid and DoA; b) cross-training in methods and procedures of both Divisions' programs for all case managers; and c) integrating the two Management Information Systems. Improved coordination is needed between referral/provider sources and the case managers in Aging and Medicaid. Some providers were confused over eligibility requirements and benefits of the various programs. They wanted to be informed when a client was denied services or benefits. However, both the Division of Aging and the Division of Social Services believe that such a procedure would violate the client's right to confidentiality.

Recommendation 5: Summaries of the eligibility requirements for each of the programs should be circulated to referral agencies and service providers.

Recommendation 6: Case managers in other agencies should be informed in writing when a referral is received. The Divisions could learn from each other.

Recommendation 7: There should be periodic joint staff meetings for the case managers in both agencies where case managers could share knowledge. The current process of determining eligibility and allocating resources is not identical in both agencies and therefore is inequitable.

Recommendation 8: Eligibility should be standardized via modular assessment instruments and services should be provided on the basis of need. An individual's access to care should not hinge upon his/her age or because he/she fits a particular funding stream. The Medicaid Waiver practice of closing cases after 90 days if client paperwork is incomplete is inappropriate for persons who are elderly or have disabilities which limit their mobility and their access to outside resources.

Recommendation 9: Clients who need assistance should be helped in preparing the applications, obtaining documentation, etc.

Recommendation 10: The practice of closing cases after 90 days, when clients have not completed paperwork, should be eliminated. Inadequate resources are allocated to Community-based LTC. In many cases, in the Division of Aging, cases are opened and immediately closed because of lack of resources. In the Division of Social Services SSBG 18 - 59 program, many clients receive only one SSBG service.

Recommendation 11: The Department needs to ensure that adequate funds are allocated to the LTC system.

Recommendation 12: When SSBG funds are "carried-over" to the next year (for example from the homemaker program in DSS), these funds should be left in LTC and not be re-allocated to other programs, such as child day care, as they have been in the past.

Recommendation 13: The Divisions need greater flexibility in the way they can utilize funds. Services offered through DSS (homemakers, day care, etc.) to the disabled are based on a model for the elderly. Young persons with disabilities have different needs than the elderly: For example, younger persons may need attendant care and adaptive equipment to increase their mobility and maximize their independence.

Recommendation 14: In addition to greater flexibility in use of the funds, case managers should be creative in their use of programs outside the Department. Clients should be surveyed about their problems and satisfaction with services. Subjective measures of client satisfaction with social programs, if done correctly, are an important measure of whether program objectives are being met and where improvements can be made.

Recommendation 15: Implement in-depth satisfaction surveys of both clients and, where applicable, caregivers. Divisions and programs contract independently with service providers. When clients move from one Division to another, for example, from CCAP or the SSBG 18-59 program to the Waiver, their service provider may change. In individual cases, a client's preference for a particular provider has been accommodated. However, the number of changes in providers could be minimized if the Divisions contracted with the same agencies when it was appropriate.

Recommendation 16: The Divisions should investigate contracting jointly for the services they both offer.

Managing JOBS Caseloads

Gary Silverstein, Institute for Family Self-Sufficiency, American Public Welfare Association

I. Introduction

This paper identifies issues to be considered when studying caseload sizes in the Job Opportunities and Basic Skills (JOBS) Training Program -- the nation's largest welfare-to-work program. It is intended to help JOBS administrators: (1) determine an optimal client-to-case manager ratio; and (2) devise strategies for targeting intensive case management services to those JOBS participants most in need of intensive assistance.

Statement of the Problem

JOBS case managers responding to a 1991 APWA survey reported average caseload sizes of 118 and, in some instances, in excess of 500 (APWA, 1992). Caseload size is a factor in the development of strong and supportive relationships between case managers and participants -- relationships that are necessary to support long-term welfare recipients in the transition to work. A study by New Jersey's Department of Human Services found that the more time case managers have for direct contact with participants, the more successful participants are in completing employment-directed activities (New Jersey, 1991). Conversely, studies of case management in JOBS and other related fields have demonstrated that excessive caseload sizes can adversely affect case managers' interactions with their clients -- e.g., their efforts become "primarily reactive rather than proactive," they have less time for assessing clients' needs, a higher proportion of their time is spent documenting client activities at the expense of direct client contacts (Intagliata, 1991).

Given such findings, an important decision for JOBS program administrators is what constitutes an optimal client-to-staff ratio. States must often balance the trade-offs between restricting caseload sizes and providing JOBS services to a sufficient number of clients. JOBS programs that strive to maintain low caseloads must often delay services to a large segment of the eligible client population until staff can be made available. In such programs, any exceptional services that are provided may be too costly on a per participant basis to justify the benefits attained by a limited number of clients. Conversely, programs with excessive client-to-staff ratios run the risk of providing inferior services that yield few, if any, tangible benefits. Under the latter scenario, it may not matter that per participant costs are minimized and large numbers of clients are served, if the resulting high caseloads hinder the client's access to quality services and achievement of desired changes.

Even when JOBS administrators have an ideal client-to-staff ratio in mind, they may be constrained by regulatory and financial factors beyond their control. For example, states are required to meet quarterly JOBS participation standards. Programs having difficulty meeting these standards may be forced to increase their caseload sizes to serve the mandated percentage of the adult AFDC population required to participate in JOBS. While these conditions are usually beyond the control of case managers, state and local program administrators can take steps to curb excessive caseloads and ease administrative burdens. At present, however, there is insufficient information about how best to achieve this goal.

This paper represents a first step by the American Public Welfare Association (APWA) to design a conceptual framework that will help state and local human service agencies assess optimal client-to-staff ratios for their JOBS programs. Specifically, this paper addresses three issues:

- What is the range of client-to-staff ratios in a sample of JOBS programs?
- What is the relationship between caseload size and client outcomes?
- What strategies are state and local human service agencies using to maximize scarce staff resources in their JOBS programs?

Study Methodology

The data used to support this paper were derived from a July 1993 telephone survey of state-level JOBS staff in 21 states and the District of Columbia, as well as a review of existing studies on employment and training programs. The purposes of the telephone survey were to: (1) obtain updated estimates of average caseload sizes for JOBS case managers; (2) assess the impact of caseload size on the efforts of JOBS case managers to serve low-income families; and (3) identify strategies that state and local programs are using to allow case managers more time for direct client contact.

States were not randomly selected to respond to the telephone survey. Rather, data on JOBS caseload sizes in individual states (HHS, 1993; APWA, 1992) were used to ensure that the sample included JOBS programs with low, medium, and high client-to-staff ratios. In addition, states were selected to provide a broad geographic distribution. Finally, an effort was made to include states that represented a good mix of urban and rural client populations and program philosophies.

II. Client-to-Case Manager Ratios in the JOBS Program

In July 1993, Institute staff conducted telephone interviews with JOBS administrators in 21 states and the District of Columbia. Each program was asked to provide estimates of: (1) the *statewide ratio* of active JOBS participants to case managers; and (2) the *range* of caseload sizes for JOBS case managers across the state. Further, states were asked to provide data on the number of *active* and *inactive* cases receiving services from case managers.

Eighteen of the 22 states in the survey provided data on the statewide ratio of active JOBS participants to case managers, while 14 provided data on the range of average caseload sizes (10 provided both a statewide average and a range of averages, 8 only provided a statewide average, and 4 only provided a range of averages). For the purposes of this study, Institute staff obtained information on the *total* number of JOBS participants that case managers work with at a given point in time -- regardless of their activity status.

Findings on Average Caseload Sizes in the JOBS Program

Statewide Averages. Of the 18 states that provided a single statewide ratio of active JOBS participants to case managers, average caseloads ranged from 35 and 290. As shown in Exhibit 1:

- 2 states reported average caseload sizes of under 45 clients per JOBS case manager;
- 7 states reported average caseload sizes between 60 and 89 clients per JOBS case manager;
- 2 states reported average caseload sizes between 115 and 125 clients per JOBS case manager;
- 5 states reported average caseload sizes between 128 and 162 clients per case manager;
- 2 states reported average caseloads in excess of 239 per case manager.

Range of Average Caseloads. Fourteen respondents provided data on the range of average caseload sizes within their states. Lower caseloads among these states ranged between 20 and 190, while higher caseloads were between 50 and 520 (high end caseloads of 300 or higher generally occurred in states that were unable to differentiate between active and inactive clients). Of these fourteen states, four only furnished data on the range of average caseloads (i.e., were unable to provide a statewide average). In these states the low ranged between 50 and 85; higher caseloads ranged between 150 and 175.

How Do Average Caseload Sizes Correspond with Other Attributes of State JOBS Programs?

This section identifies trends that distinguish states with lower caseloads from those with higher caseloads. For the sake of simplicity, this discussion excludes the four states in the study that only provided data on the range of average caseload sizes -- i.e., were unable to furnish a single client-to-case manager ratio for the entire state.

Caseload Standard and Wait List. As shown in Exhibit 1, the nine states with lower average caseloads all imposed official caseload limits or encouraged local agencies to restrict client-to-staff ratios. In four of these nine states, an official caseload standard, ranging from 35 to 60 clients, was in place. The actual statewide average was at or below the standard in all but one of these states. In a fourth site, actual client-to-case manager ratios were 35 percent higher than the state's caseload standard. Administrators in the remaining states have established unofficial caseload targets that local agencies are encouraged to meet. In all but one of these states, the objective is to keep caseloads in the double digits.

Only one of the nine states with average caseload sizes of 115 or higher has an official caseload standard. This standard of 50 clients per case manager, however, only encompasses clients enrolled in a special program serving families with severe barriers to self-sufficiency. A second state is considering a caseload standard of 220 (the current average caseload in this state is 290 -- i.e., 162 active clients and 128 inactive clients). None of the nine states with higher caseloads is unofficially encouraging local agencies to restrict caseload sizes.

All of the states indicated use of "wait lists" to keep clients in an inactive or holding status until sufficient resources are available. However, the role of these lists differs across states. States in the study with lower client-to-staff ratios report that wait lists are primarily used to contain caseload sizes -- i.e., clients remain inactive until case managers are available to serve them. Of the nine states in the study with higher caseloads, five assign clients to a case manager as component slots become available. Thus, in these five programs, the availability of component slots -- rather than case manager availability -- influences client-to-staff ratios. This suggests that some states are deliberately keeping JOBS caseload sizes low (i.e., to provide intensive case management to all participants), while others are allowing JOBS caseload sizes to expand so that a larger number of mandatory clients can be served. As will be discussed later, however, several high caseload states have taken steps to target intensive case management to clients with severe barriers.

Among the 18 states in the study sample, efforts to restrict caseload sizes are clearly associated with lower client-to-staff ratios. States that maintain caseload standards or impose unofficial targets have been able to restrict caseload sizes. Conversely, states which place fewer controls on the influx of JOBS participants have relatively higher client-to-staff ratios. In addition, it appears that states with lower caseloads are relying primarily on wait lists to contain caseload sizes. Another option -- hiring additional case managers to reduce caseload sizes -- has not been widely used among the states that were studied.

Percentage of AFDC Families Participating in a JOBS Component. States that elect to limit caseload sizes through use of a wait list run the risk of serving a proportionally smaller segment of the eligible client population than those that maintain higher caseload sizes. As shown in Exhibit 1, however, the JOBS program data for FY92 (see JOBS-ACF-Information Memorandum-93-10) do not reveal a relationship between average caseload sizes and the percent of *mandatory* AFDC clients served by a state's JOBS program. This is likely due to the fact that states with

Exhibit 1: How Do Average Caseload Sizes Correspond to Other Attributes of State JOBS Programs?[9]

	Study Sample		
	Study Sites with Caseloads Sizes of 90 or lower (n=9)	**Study Sites With Caseloads Sizes of 115 and higher (n=9)**	**Nationwide (n=51)**
Average Number of *Active* JOBS Participants Per Case Manager	35-45 clients (2 states) 60-89 clients (7 states)	115-125 clients (2 states) 128-162 clients (5 states) 239-280 clients (2 states)	n/a
Does State Have an Official or Unofficial Caseload Standard?	Official (4 states) Unofficial (4 states)	Official (2 states) Unofficial (1 states)	n/a
Do Some Local JOBS Programs Have a Wait List That is Governed By Case Manager Availability?	yes (9 states)	yes (4 states)	n/a
Percent of the State's Adult AFDC Population That is Required to Participate in the JOBS Program	43.0%	49.1%	42.9%
Percentage of *Mandatory* AFDC Clients Participating in a JOBS Component in FY92	14.6% (median) 6.6% - 42.2% (range)	14.8% (median) 9.5% - 31.8% (range)	18.0% (median) 6.6% - 77.8% (range)
Percentage of *All* Adult AFDC Clients Participating in a JOBS Component in FY92	5.2% (median) 2.4% - 11.7% (range)	6.7% (median) 5.0% - 11.2% (range)	6.5% (median) 0.7% - 31.4% (range)
Percentage of JOBS Funds Drawn Down As a Percent of the Total JOBS Funds Available to the State in FY92	68.5% (median) 34% - 99% (range)	78.0% (median) 46% - 105% (range)	74.0% (median) 22% - 128% (range)

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[9] Source: Telephone survey with JOBS staff in 22 states, HHS-JOBS-ACF-IM-33-10, *1993 Green Book*.

lower client-to-staff ratios are targeting JOBS resources to those AFDC clients assessed as being mandatory for JOBS.

One problem with comparing mandatory participants served across study sites, however, is that the percentage of adult AFDC recipients required to participate in JOBS differs across states. Thus, for cross-site comparisons, it is also useful to examine the extent to which states are providing JOBS services to *all* adult AFDC recipients.[10] For study states reporting lower caseloads, the median percent of adult AFDC recipients enrolled in a JOBS component was 5.2 percent in FY92. The corresponding median was 29 percent higher in states reporting higher caseloads (6.7 percent). This suggests that states in the survey with higher caseloads are serving a slightly higher percentage of their total adult AFDC population than those states with lower ratios of case managers to clients. This likely reflects the deliberate intention of some lower caseload states to provide intensive case management services to all JOBS participants. It should be noted, however, that this finding considers the *extent* to which eligible clients are being served, not the *quality* of these services.

States' Spending on JOBS. In FY92, the median percentage of state JOBS expenditures and obligations as a percent of total available JOBS funds was 74 percent nationwide (see Exhibit 1). Within the study sample, the states with lower caseload sizes expended a lower percentage of available JOBS funds (68.5 percent) than did states with higher caseloads (78.0 percent). These preliminary findings – that states with lower client-to-staff ratios serve a smaller segment of the eligible client base (i.e., adult AFDC recipients) and draw down a smaller percentage of available JOBS funds – merit further study.

Caseload Size and the Quality of Case Management Services

The Institute's telephone survey identified a number of trends associated with higher client-to-staff ratios that can adversely impact the effectiveness of case management services. State administrators indicated that case managers with high caseloads are often unable to closely monitor or assist with a client's progress. They are also less likely to have the time needed to conduct comprehensive assessments, work more intensively with unmotivated clients, or meet with local employers to arrange for employment opportunities. As a result, state JOBS staff expressed concern that some JOBS participants may not receive adequate services as caseload sizes rise.

These findings are corroborated by previous studies of welfare-to-work programs. For example, a study of the California Greater Avenues for Independence (GAIN) Program found that some administrators chose to stretch program resources by maintaining higher client-to-staff ratios, while others "believed that lower caseloads and closer individualized attention would be essential to GAIN's effectiveness, and some decided to serve only a portion of the county's total pool of registrants in order to keep staff caseloads low" (Doolittle and Riccio, 1992). The study also found that high caseloads delayed case managers' responses to nonattendance in component activities and hindered the use of

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[10] Although this definition excludes some of the families who meet with case managers, it serves as a useful measure of the percentage of all adults who are actively participating in a JOBS component. Also, the denominator in this definition includes all AFDC families. It therefore encompasses households not required to participate in JOBS because they have been exempted, are living in parts of the state that are not covered by the JOBS requirement, or are under sanction. The federal participation rate cited previously uses a different denominator – i.e., those participants who are *required* to participate in a JOBS activity.

"persuasion" to increase program participation. An analysis by the New Jersey Department of Human Services also studied the link between caseload size and effective case management:

> The more time case management staff have for working directly with a client or a client's family member to develop and implement a plan which matches the client's needs, the more successful a county is in processing clients through the system. This is found to be particularly true when dealing with those clients believed to be the most difficult to serve (New Jersey Department of Human Services, 1991).

A number of studies have examined the relationship between caseload size and the quality of case management services in other social service professions. Although these studies generally focus on case managers with lower client-to-staff ratios than those maintained in JOBS, they provide insights into the consequences of high caseloads. For example, a 1980 evaluation of case management for chronic psychiatric patients in New York State found that increasing caseload sizes from 15 clients to 30-50 clients had a significant impact on case managers' "working styles" (Intagliata, 1992). Specifically, case managers who found themselves with less time for individual clients reported that:

- their efforts became "primarily reactive rather than proactive such that the majority of their time was consumed responding to crises rather than anticipating problems and helping clients to plan ahead for them" (Ibid.);
- they had less time for assessing clients' needs;
- they were forced to do things for clients, instead of working with individuals to help them become more independent;
- clients took an increasing role in initiating contacts with case managers, thereby raising concerns that the needs of some individuals were being neglected; and
- a higher proportion of their time was spent documenting client activities, at the expense of direct contacts with clients.

The study concluded that these developments threatened the "quality and effectiveness" of the overall case management approach.

Caseload Size and Client Outcomes in Welfare-to-Work Programs

The link between intensity of case management services and client outcomes is difficult to establish. This is because a number of external factors (e.g., quality and availability of JOBS activities) could also be largely responsible for such readily observable outcomes as increased earnings or reduced welfare payments. In addition, it is difficult to quantify many of the tangible benefits of case management -- e.g., improved self-esteem, enhanced motivation, educational achievement.

A study of Competency-Based Case Management (CBCM) in Virginia Beach, Virginia (1990) found evidence that the effectiveness of intensive case management decreased as staff caseloads expanded. CBCM was found to be effective in that treatment group clients were more likely to exit welfare than their control group counterparts. The study found, however, that treatment group clients were not more likely to find employment. Rather, they were more likely to acknowledge outside income and reject subsidies for which they were eligible. The study concluded that CBCM succeeded in "mobilizing clients' sense of self-worth, honesty, or pride" (Rohrbaugh, Nezlek, and Galano, 1990). No direct link between caseload size and client outcomes was established, however, in part because the frequency of interactions between case managers and clients over time was not measured. A second study, of the Lincoln (Nebraska) Action Program Demonstration Project, also found evidence that the intensity of JOBS case management and frequency of home visits are correlated with academic achievements and removal of family barriers to self-sufficiency (Hoeltke, 1993).

A forthcoming study by the Manpower Demonstration Research Corporation (MDRC) should provide significant insights into the link between caseload sizes and client outcomes. As part of its California's GAIN study, MDRC randomly assigned GAIN participants in Riverside County to two groups of staff having workloads of approximately 50:1 or 100:1 (Gueron and Pauly, 1991). To negate the influence of staff characteristics and previous work experience, case managers were also randomly assigned to the two study groups. Because the service strategies and availability of component services are consistent between the two client pools, the evaluation provides a unique opportunity to study the influence of client-to-staff ratios on process outcomes (e.g., attendance in employment and training activities, duration in program activities) and client outcomes (e.g., employment status, wages, reductions in welfare payments). It should be noted, however, that even the higher of the client-to-staff ratios being compared is well below the average caseload size in many states. The study's findings are expected to be released in the Spring of 1994.

III. Strategies for Handling JOBS Caseloads

All of the JOBS staff members contacted by the Institute expressed concern about rising client-to-staff ratios in the JOBS program. Some of the states' representatives have taken steps to restrict case managers' caseload sizes, while others have allowed average caseload sizes to rise. As part of the Institute's telephone survey, state JOBS staff were asked to describe the strategies used to: (1) restrict JOBS caseload sizes; (2) manage excessive client-to-staff ratios; and (3) target individualized services to JOBS families with severe barriers to employment.

Strategies for Restricting Access to the JOBS Program

None of the JOBS programs surveyed is able to serve the entire population of mandatory JOBS participants. This section describes strategies that states are using to control access to their JOBS programs.

Caseload Standards. According to a 1991 mail survey of state JOBS administrators, just over one-third of states impose a caseload standard on their local JOBS programs (AWPA, 1992). The average permissible client-to-staff ratio among these states was 98, with a range of 35 to 325.

The Institute's July 1993 telephone survey obtained more detailed information about formal and informal efforts to limit caseload sizes. The states reporting the lowest client-to-staff ratios are all taking some official or unofficial steps to keep caseloads low. Among the 22 surveyed states:

- Three have a caseload standard of under 60 clients per case manager. (In response to financial constraints and pressure to serve more mandatory JOBS participants, one of these states intends to raise its caseload standard from 55 to 75 in October 1993.)
- Two have a caseload standard of over 125 clients per case manager.
- One has a caseload standard of 50 for harder-to-serve JOBS participants (predominately target group members). There is no corresponding client-to-staff ratio requirement for non-target group participants.
- Four have specified unofficial goals or targets that local agencies should strive to meet. These targets range from 50 to 117 clients per case manager.
- Two are in the process of developing official caseload standards of 75 and 220.
- One originally had a statewide client-to-staff ratio standard of 80:1 that was subsequently revoked (actual client-to-staff ratios in this state currently average around 240:1).
- Seven have no caseload standard and make no effort to encourage smaller caseload sizes.

State JOBS staff were also asked to describe the steps involved in devising an appropriate client-to-case manager ratio. In a few states, time and motion studies were used to develop and revise a caseload standard. In others, the official (or unofficial) caseload standard was established in less formal ways – e.g., communications with other states regarding comparative client-to-staff ratios.

Wait Lists. All of the states in the survey sample with caseloads of 90 or fewer reported that local agencies use wait lists to contain client-to-staff ratios. While case manager availability governs entrance into JOBS in these nine states, programs rely on a variety of criteria to select clients from their wait lists. For example, some programs prioritize wait listed clients so that volunteers and target group members are selected ahead of all others. In others, clients who have been wait listed the longest are placed at the top of the JOBS ledger. In addition, several states in the survey indicated that they select volunteers and target group clients who are most likely to satisfy the federal participation rate – i.e., can easily be scheduled in JOBS activities for an average of 20 hours per week.

Other Strategies for Restricting Access to the JOBS Program. States identified other strategies that local agencies are using to restrict access to their JOBS programs, including:

- *Screening out exempt AFDC clients at intake.* Several surveyed states are providing training to those front-line staff responsible for determining an AFDC recipient's JOBS status (i.e., exempt, non-exempt, volunteer). This training, generally provided to AFDC eligibility staff, is intended to restrict the number of exempt clients who are inappropriately referred to a JOBS wait list. Reliable screening of exempt and non-exempt clients is especially important in programs where case managers are required to assess prospective participants within 30 days of referral to JOBS and/or meet with all wait-listed clients on a semi-annual or annual basis.

- *Defer Clients With Severe Barriers to Employment.* In a number of states, mandatory JOBS participants with the most severe barriers to self-sufficiency are deferred for an indefinite period of time. This is often done because programs lack the resources or component slots to serve individuals with severe supportive service needs. For example, one surveyed state does not currently require clients who have not progressed beyond the 8th grade and lack work experience to participate in JOBS. In a local agency in another surveyed state, clients testing below a certain level during the orientation are deferred for good cause.

Strategies for Managing Excessive Caseload Sizes

States in the survey sample reported a variety of strategies for managing larger than optimal client-to-staff ratios. One apparent method, expanding the number of case managers, has been used only sparingly. This is not surprising, given the fiscal constraints in most JOBS programs. Additional methods cited by state JOBS staff are discussed below.

Shifting Case Management Tasks to Other Staff. One rather obvious method for freeing up a case manager's time to serve additional clients is to allocate paperwork tasks to other staff. Most of the surveyed states indicated that case managers receive at least some clerical support for such administrative tasks as data entry, typing, filing, monitoring attendance of clients enrolled in education and training components, scheduling clients for group activities, and generating call-in notices.

Some agencies have found creative ways to provide administrative support to JOBS case managers. For example, some states provide case managers with case aides who handle all attendance and client monitoring functions (case managers intervene whenever case aides determine that a JOBS participant is failing to attend a component activity). Two of these states report using JOBS participants enrolled in the Community Work Experience Program (CWEP) to serve as case aides and/or provide clerical support. In addition, case managers in one state use collateral contacts with service providers in lieu of monthly progress contacts with clients. By shifting much of the monitoring burden to the service provider, case managers in this agency are able to obtain attendance information for a group of clients at one time.

JOBS programs in the survey sample are also shifting non-clerical case management tasks to specialized workers. Some agencies allocate specialized functions -- e.g., conducting assessments, arranging child care -- to a single worker or unit. Providing such support can free up a case manager's time for other participant-oriented activities. It can also allow a single worker (or team of workers) to tackle time consuming issues without straining limited case management resources. One of the surveyed states is shifting some case management functions to a contractor to free up case managers' time to work with more JOBS participants (as a result of this strategy, the state is also raising its caseload standard from 55 to 75).

Automating Case Management Functions. Another method for freeing up case managers' time for participant-oriented activities is to automate information, referral, and administrative functions. Many of the agencies included in the survey have developed (or are in the process of developing) user-friendly automated information systems that enhance a case manager's ability to monitor attendance, generate letters to clients, prepare monthly administrative reports, and share information about participants with other service providers in an appropriate and timely manner.

Conducting Case Management Activities in Group Settings. Many of the states in the survey maximize case management resources by conducting client activities in a group setting. The most common group activities utilized by case managers are orientations about JOBS, assessments, counseling (through peer support groups), and client monitoring. To facilitate group exercises, agencies are also assigning clients with similar characteristics (e.g., teenage parents, substance abusers) to the same case manager. State JOBS staff indicated that this approach enhances the potential for group support activities and allows case managers to realize economies of scale by working with clients who share common problems. One of the surveyed JOBS programs assigns clients engaged in educational components to one case management unit, while clients enrolled in labor attachment activities are assigned to another unit. In addition, case managers in at least two of the surveyed states conduct routine visits to service delivery sites to meet with groups of clients on-site. Case managers in one of these agencies meet with clients in the cafeteria of a local school and schedule monthly office hours at service provider sites.

Providing Case Managers With Adequate Supervisory and Community Support. The amount of time that case managers can make available for direct client contact is determined, to some extent, on whether the existing linkages with local service providers are sufficient to meet the diverse and comprehensive needs of the community's JOBS population. A number of case management studies in related fields have demonstrated that when services are not readily available, case managers are required to devote much of their time to either providing or creating the needed assistance (Intagliata, 1991). Conversely, case managers' capacity to handle higher caseloads is often enhanced when they are able to rely on timely and reliable referrals for such activities as counseling or life skills. Another form of supervisory support is frequent meetings between case managers and their managers to identify potential time saving measures. For example, case managers and supervisors working together in one surveyed state have eliminated unnecessary forms and identified techniques for streamlining paperwork.

Training in Effective Case Management Practices. Several of the states in the telephone survey suggested that training be provided to front-line staff to enhance their capacity to spend more time with JOBS participants. The Institute's 1991 mail survey found that the majority of states provided some level of training to staff before they became case managers (APWA, 1992). This training generally focused on the JOBS program, Family Support Act, case management, and assessment techniques. Less than half the states, however, provided training in such topics as counseling, family development, cultural diversity, or developing and maintaining relations with community-based organizations. State agency staff also identified the following as issues on which their case managers most need training and technical assistance: (1) problem-solving; (2) time-management; (3) methods for monitoring participants' progress; (4) counseling; (5) inter- and intra-organizational skills; and (6) methods to evaluate success of case management.

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Strategies for Targeting Case Management to JOBS Participants with Severe Supportive Service Needs

Some of the surveyed states have established policies that target case management to those most in need of multiple services – e.g., JOBS target group members, participants in need of multiple social services, or individuals experiencing an immediate crisis. By establishing priority populations who will receive intensive assistance, these programs strive to shift higher caseload sizes to those case managers who primarily work with job-ready clients. This policy avoids undermining the case management approach for those clients with the most severe barriers.

States are using a variety of approaches for targeting case management resources to those families with the most severe barriers to self sufficiency. Several of the surveyed states report that volunteers generally receive significantly fewer case management services than mandatory participants. In addition, clients needing intensive case management (e.g., teenage parents) are often assigned to special case managers with lower caseloads. In addition, two states in the study triage clients at the point of AFDC eligibility determination. Their educational status and work history determine the component path they will take, as well as the type and intensity of case management they will receive.

IV. Conclusion

Under the Family Support Act of 1988, states are provided considerable discretion in terms of the design and implementation of their JOBS program. Previous studies have found significant diversity in the ways that employment and training services are provided at both the state and county levels. Preliminary findings from the Institute's survey of 22 JOBS programs suggest that the intensity of case management provided to JOBS participants also varies considerably across states. While some states have restricted JOBS caseload sizes, others have maximized the number of clients served by maintaining client-to-case manager ratios in excess of 115:1. In a few of the surveyed states, the decision to limit caseload sizes is part of a deliberate effort to provide intensive case management to *all* JOBS participants. Many of the remaining states indicate that the need to meet federal participation requirements in times of fiscal austerity make it difficult to restrict client-to-staff ratios.

This paper represents a first step in the Institute's ongoing efforts to study the relationship between caseload sizes and the effectiveness of case management services. The information obtained through the Institute's telephone surveys and review of existing literature suggest several additional research questions that require more in-depth analysis:

- What factors do JOBS administrators consider when assessing optimal caseload sizes?
- Does effective case management lead to improved client and family outcomes?
- What are the characteristics of JOBS participants?
- What practices are local agencies using to manage caseloads? Can these strategies be replicated in other sites?

JOBS case managers require sufficient time to address the needs of AFDC families with severe and multiple barriers to self-sufficiency. Several face-to-face sessions may be needed to work with a participant who lacks basic work skills or motivation, enters JOBS at a time of immediate crisis, and/or requires a variety of intensive supportive services. The size of caseloads is obviously one of the most important considerations in this regard. Future Institute publications will examine state and local efforts aimed at building case managers' capacity to help participants maximize the opportunities available under the JOBS program.

Services to Runaways and At-Risk Youth

Sue E. Calland, Texas Department of Child Protective Services

This presentation describes the services available to runaways and at risk youth through the Texas system. Types of services rendered and contracting community based organizations and mental health programs for runaway and at-risk children are discussed.

For further information about this presentation, please contact the author (see address list).

Estimates, Forecasts, and Outcome Measures

Moderated by Florence C. Odita, Ph.D., J.D.
Ohio Department of Human Services

Medicaid Budget Estimation Methods: Results of a Survey of Medicaid Budget Officers - Deborah J. Lower, Ph.D., David M. Griffith and Associates, Ltd.

Justifying Program Funding: The JOBS Experience in New Jersey - Martey Dodoo, Ph.D., New Jersey Division of Family Development

Forecasting - What a Difference a Year Makes - Morris Williamson, Texas Department of Human Services

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Medicaid Budget Estimation Methods: Results of a Survey of State Medicaid Budget Officers

Deborah J. Lower, Ph.D., David M. Griffith & Associates, Ltd., Health & Human Services Division

Background

Each State Medicaid Program is required on a quarterly basis to submit budget forecasts for the coming quarter and for the next two years. In the past few years these estimates have been off by as much as 20% for some states. There are several reasons for the discrepancies including law suits, program eligibility expansions, new program implementation, disproportionate share hospital payments (DSH) and federal mandates.

To provide some guidance on the budget estimation methods used by the states, the Colorado Department of Social Services Medicaid Budget Office staff conducted a telephone survey in the spring of 1992. During the survey it became apparent that Medicaid Budget Office staff were very interested in determining what techniques were being used in other states to assist them in responding to legislative and executive branch questions. To provide additional information to states, a survey was conducted by David M. Griffith & Associates, Ltd. (DMG) during the spring of 1993.

Methodology

The survey form was developed in conjunction with Colorado Medicaid Budget Office staff, reviewed by HCFA regional office staff and shortened to nine (9) pages. The survey was mailed to all states and the District of Columbia the first week of March requesting a return by March 31. The final survey form from the 43rd state was received the last week of July for a response rate of 84.3%. A listing of the states which responded to the survey is found in Attachment 1.

The survey instrument included four (4) sections:

- ☐ Medicaid Budget Forecasting
- ☐ Medicaid Expenditure/Service Data
- ☐ Medicaid Budget and Finance Office
- ☐ Other Requested Information

Descriptive information from each section of the survey has been compiled in a format which summarizes state responses rather than identifying states. Information on specific states can be obtained by contacting the author.

Medicaid Budget Forecasting

1. Utilization of State Staff: The survey results found that all reporting states conducting Medicaid budget forecasting in-house with existing staff. Thirteen (13) of the reporting states also provided their own claims processing, rather than contracting out that function.

2. HCFA-37 FTE Requirements: The quarterly completion of the HCFA-37 required from .1 FTE to 15 FTE with an average of 1.588 with the outlier of 15 FTE removed. The FTE numbers were estimates and several States responded that the completion of the HCFA-37 was time intensive for several staff at particular times of the year, but it was not equivalent to a full-time job. It was also noted by reporting states that the completion of the HCFA-37 did not in and of itself remove their time commitment to complete state budget forecasts which may need to be completed using different eligibility categories and/or reporting periods.

   The number of hours devoted to the completion of the November HCFA-37 ranged from 24 hours to 375 hours with the February HCFA-37 times ranging from 12 hours to 188 hours. (One State reported 1200 hours for each report.) The average staff time for November was 114.7 hours and it dropped to 76.85 hours for the February report. It should be noted that the November report was the first time the staff were required to complete the HCFA-37 and to send the report on-line to Baltimore. This fact would account for a portion of the increased time. Also, the November and May reports include additional information which hasn't been required to be collected and reported in February and August.

   A comparison was made between the amount of staff time required for completing the HCFA-37 and the reported size of the Medicaid program. The analysis showed that there was not a significant relationship between financial size of the Medicaid Program and the FTE and hourly requirements (r=.166). Small states have the same collection and reporting requirements as large states.

3. HCFA-37 Staff Backgrounds: The survey instrument inquired about the backgrounds of the staff working on the HCFA-37. Only three States reported staff with an actuarial background, 31 reported staff with accounting experience; 33 had staff with budget analyst background; 18 had staff with statistics background; 14 reported staff with program/policy analyst background; and 4 States reported having staff with either a CPA, an economist with forecasting experience, or a research management analyst.

4. Caseload Projections: Caseload projection methods were reported in varying degrees of depth and complexity. Some states reported that caseload estimates were prepared by demographers, staff of the governor's office or the legislature or forecasters for specific programs (e.g., AFDC). From the study, the following methods of preparing caseload estimates were presented:

a. Eligibility data was used in 37 states with the most prevalent eligibility data period reported being monthly over an average of almost 5 years;

b. Population categories were discretely reviewed in 31 states;

c. 27 states attempt to figure in the impact of federal mandates on caseload;

d. 23 states use program specific information; and

e. 5 states attempt to consider retroactive eligibility factors.

f. Claims payment date was reported as being used in 28 states while 8 states used service date and 4 states use both service date and payment date. Six (6) states reported that they do not have routine access to extract data. The lag time between a claim being paid from service date was very short in some states and up to two years in one state. The payment time also varied by service (e.g., nursing home claim versus hospital claim).

5. Utilization Forecasting: Methods reported by the states were predominantly historical analysis with some states adjusting the trend line based on projected eligibility changes.

   a. 19 states use eligibles for forecasting utilization, 12 states use recipients served, 11 states use both methods, and Arizona uses eligible months.

   b. 18 states adjust utilization projections based on seasonality but the adjustment may only be for particular services such as nursing home or hospitalizations.

6. Price Level (Provider Reimbursement) Forecasting: Typical methods were based on some type of index such as CPI, DRI, or state/city specific index of health care costs. States also considered the need to rebase the cost/unit based on known changes or the result of lawsuits. Historical patterns were not reported as often as a predictor of price level as found in caseload or utilization projections. Price level changes were broken out by service type in 37 states, by service type and eligibility class in 21 states, and only 8 states used other demographic categories.

7. Changing Forecasts: The states reported frequency of changing forecasts was most often on a quarterly basis (16 States), but 10 states reported changing the forecasts as needed or as directed.

8. Anticipated Medicaid Budget Growth: The rate of growth anticipated for State FY 93-94 ranged from 3.7% to 32% with the average at 14.46%. States were asked to rank the primary factors influencing growth of the Medicaid budget. As expected, the factors in order were:

(1) Increase In Number of Eligibles (Caseload)
(2) Economic Factors Influencing Price
(3) Increase in Utilization

The most difficult problems for preparing Medicaid budget projections were reported as: last minute program and policy changes; accurately predicting population growth; accurately predicting utilization when there are constant increase in enrollment; and state budget constraints versus federal mandates. Other problems mentioned included validity of data used for projections with fiscal agent change, technological advancements which contribute to more units of service being provided per each funded visit or encounter, fluctuations in cash payments versus service dates and retroactive adjustments.

9. Software Packages: Software used by states for caseload budget forecasting ranged from Lotus 1-2-3 and Lotus Symphony; Quattro Pro; SAS, SPSS, Excel, Forecast Pro - London School of Economics. Five states reported having mainframe forecasting programs. One state is currently developing through an advanced planning document (APD), a PC-based forecasting program which uses the Florida mainframe budget estimation model.

Medicaid Expenditure/Service Data

States reported that Medicaid represents from 4% to 52% of the State Budget, with the average being 15.96%. The annual per capita cost for State FY 91-92 for all recipient groups was reported as an average of $3,275 with the range being from $141 to $8,400. Some states did not report mental health or institutional costs in their average service dollars.

The average monthly HMO enrollment was "0" in 15 states and the valid ranges were 553 to 384,377. When asked about managed care program development, most states reported some movement in the area of either a primary care physician or primary care case management program.

One of the factors which has been thought to have driven up Medicaid costs in states is the number of births paid for by Medicaid. In the states which have that information (32 out of 43), the range was from 14% to 56% with the average being 36.4% of all live births in State FY 91-92 reimbursed by Medicaid. Another factor suspected in increasing expenditures beyond estimates has been the number of states involved in rate related lawsuits (Boren Amendment suits). Twenty-two (22) states in the survey reported this situation.

In dealing with the problem of a lack of resources to meet budget obligations, the states reported the following options: request a supplemental appropriation (41 states); cut payment rates for specific services (15 states); cut payment rates across the board (8 states); and only two (2) states can exercise overexpenditure authority. Twenty-four (24) states reported the ability to cut services, but when this option has been elected it has been done as follows: cut optional services (16 states); set additional service limitations (14 states) and cut populations served (10 states).

Medicaid Budget and Finance Office

The role and position of the Medicaid Budget and Finance Office varies from state to state. Of the 43 states reporting, one state identified that this was just one component of the overall Medicaid program and not a separate unit.

Reported responsibilities of the offices or units included: budget calculations (42 states), budget presentations (34 states), conduct training (12 states), cost and utilization analysis (5 states), monitoring the budget (5 states), program implementation and review (3 states), and statistical analysis (3 states).

The average size of the office was reported from 1 to 44 with the average being 7.8 FTE. Almost half the respondents reported state imposed FTE limitations on the Medicaid program (21 states).

The primary responsibility for the Medicaid Budget was identified as with Budget and Finance in 17 states; with Program Administrators in 9 states; with Department Administration in 7 states; with Program Budget Analysts in 3 states and with a combination of Budget and Finance/Program Administration in 3 states and Budget and Finance/Department Administration in 3 states.

Communication between Medicaid Budget and Finance and Program has been formalized in 60% of the states (26 states). The reported communication techniques varied from involvement in weekly meetings, to biweekly meetings, monthly budget meetings, a standing budget committee, or staff deployed from budget to program for regular weekly meetings. It was reported that program staff have direct access to expenditure data in 35 states. However, several states reported program staff had not acquired skills to use the budget information for program management or reviews.

When a new Medicaid service has been developed or added to the benefit package, Budget and Finance staff reported obtaining information for budget forecasting by using program information (41 states), obtaining information from other states (40 states), using census data (36 states), talking with insurance companies (14 states) or using other sources such as providers, actuaries, health/research data or historical patterns.

On the survey form was a question which asked if the governor's office had written guidelines for budget preparation. In 40 states the answer was yes, while only 5 states said that the guidelines would be helpful for Medicaid budget forecasting. Assistance requested in budget preparation was the following: budget conference (22 states); technical write-ups (20 states); and training for program staff (18 states). Other ideas presented included a closer relationship with HCFA, actuarial training, providing annual guidelines for estimates and enhanced federal funding for FTE preparing the HCFA-37.

Other Requested Information

Electronic fund transfer (EFT) for claims payment has been of growing interest to states. In the survey eleven (11) states reported using EFT and 10 states said it had accelerated payments. Another factor impacting expenditures has been the extent of outreach efforts conducted by the states to inform new eligibles of available programs (e.g., EPSDT). Thirty-seven (37) states reported outreach efforts to reach new eligibles and of those states 25 reported that the outreach efforts have had a discernable impact on Medicaid expenditures through increased utilization.

Summary

States have devoted considerable time and effort into preparing federal Medicaid budget estimates (HCFA-37) which doesn't necessarily correspond to the extensive efforts states expend in preparing the state Medicaid budget. States have requested on this survey document additional assistance which could be provided by HCFA through a conference, technical write-ups and developing a closer working relationship with states. Software packages which could assist states in preparing federal estimates in a timely manner, drawing down mainframe claims payment and eligibility information would be of benefit to states. That effort has started in at least a few states.

In responding to the dramatic growth in Medicaid budgets, states have initiated a movement to some form of managed care. Thirty states (30) reported either enhancing or expanding existing managed care programs or a movement the primary care physician or primary care case manager approach, with more extensive use of HMOs and prior authorization review and/or utilization review. In order to accomplish these cost containment efforts, several states have requested or are in the process of obtaining waivers to operate the programs to meet individual state development and financing needs.

States also reported various refinancing options to increase Medicaid services while reducing state funding demands. These efforts included use of public schools as EPSDT providers, disproportionate share hospital payments, rehabilitative service option for residential treatment centers and use of administrative or targeted case management.

Attachment 1

States Responding to Medicaid Budget Officer's Survey by 7/31/93

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Delaware
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
South Carolina
South Dakota
Texas
Utah
Virginia
Washington
Wisconsin
Wyoming

Justifying Program Funding: The JOBS Experience in New Jersey

Martey S. Dodoo, Ph.D., New Jersey Division of Family Development

Background

The U.S. Congress funds the federal Job Opportunity and Basic Skills Training (JOBS) program by making federal funds available to match state funds. The procedure requires that state agencies put up their own state funds up front. Due to ongoing budget difficulties, however, many state agencies are having great difficulty obtaining the state funds from their legislatures. Legislators want to know exactly what state money is buying, and agencies have had to justify, to a greater extent than they did before, all state funding for the JOBS program.

State agencies have had to justify funding levels to legislatures using various measures of program effectiveness. In some cases, legislators have requested specific data in reports. In other cases, researchers in state agencies have had to develop and compute various measures of program effectiveness to convince legislators it is worth funding these federal programs.

Methods

The two groups of JOBS program effectiveness measures that are reported to the New Jersey legislature are: 1) Employment indicators - The proportion of JOBS participants who obtained employment, their average starting wages, work hours per week, and the proportion who receive medical insurance benefits from their employers and 2) AFDC dependency indicators - The average AFDC recidivism rates and the average number of months spent off AFDC by former JOBS participants.

The report presents the methods used to compute these and other measures. It also presents the methods used by New Jersey to obtain the data required to fulfill the standard federal participation (FSA-108) and targeting requirements.

Key Results

The results include the past values of the program effectiveness measures for former JOBS participants:

- The average hourly wage at placement is about $7.00.
- About 1 in 4 indicate placement wages below the statutory minimum level.
- The average work week is about 35 hours.
- About 1 in 2 indicate they receive health insurance benefits.
- The average AFDC recidivism rate is about 24% for those who have been off AFDC for at least 24 months.

For further information on this presentation, please contact the author (see address list).

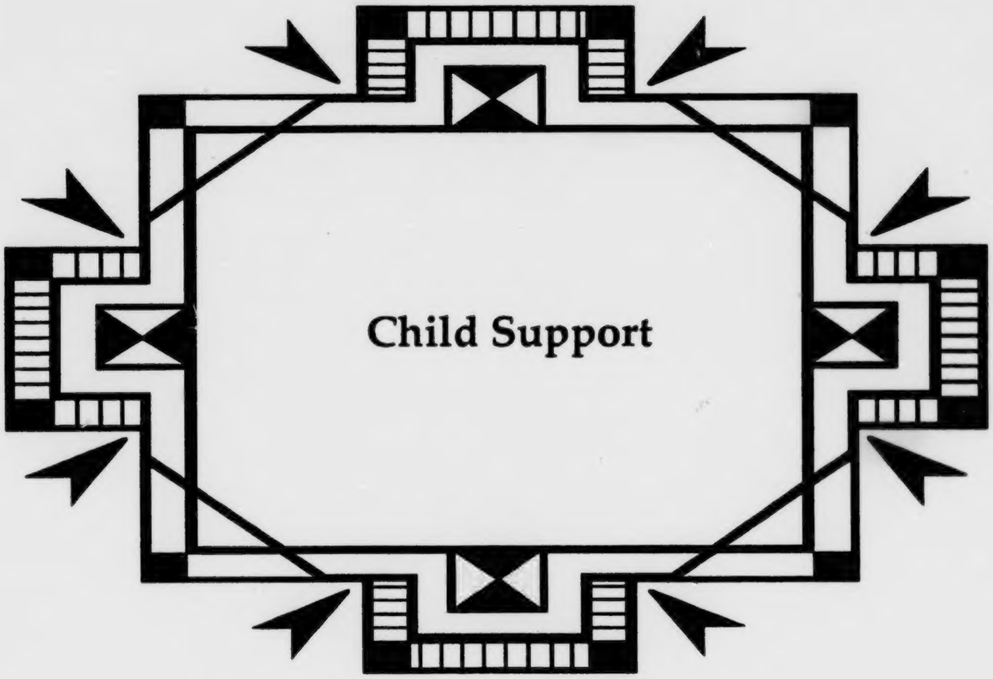
Forecasting - What a Difference a Year Makes

Morris Williamson, Texas Department of Human Services

Approaches to forecasting of major caseload measures (AFDC, Food Stamps, Medicaid, etc.) continue to evolve within the Texas Department of Human Services. Texas is projected to experience funding 'short-falls' for state fiscal years 1994 and 1995. Initial forecasts for this period were done in 1992. This was a period of increasing caseload growths. Most recently, these trends have been slowing down.

ARIMA, Autobox, State Space, Census X-11 deseasonalization, Box Jenkins, and other techniques are used and the merits discussed. The use and effectiveness of 'completion factors' for some data series were presented. The use of 'fixed forecast' techniques, and preliminary efforts using multiple regression and stochastic model efforts were discussed.

For further information on this presentation, please contact the author (see address list).



Child Support

Moderated by Bart Hopkin
Utah Department of Human Services

The Costs and Effects of a Child Support Assurance Program - Sandra Clark, The Urban Institute

Non-Custodial Parents' Ability to Pay Child Support - Elaine Soresen, Ph.D., The Urban Institute [Oral presentation only]

Welfare Reform and Child Support - Wendell Primus, U.S. Department of Health and Human Services [Oral presentation only]

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The Costs and Effects of a Child Support Assurance System

Sandra Clark, The Urban Institute

Introduction

Interest in the concept of a national child support assurance program has grown out of concern over the prevalence of child poverty and awareness that lack of financial support by noncustodial parents contributes to this problem. In 1989, 11.4 million custodial mothers with their children under 21 lived apart from the child's father; nearly 4 million of these families lived in poverty.[1]

Several recent proposals called for establishing a child support assurance (CSA) program, whereby the government would pay a benefit to children when child support is not received. Depending on its design, a CSA program could have several positive outcomes. First, it could provide an incentive for custodial parents to establish paternity, seek and obtain a support order, and cooperate with enforcement agencies, if CSA benefits are contingent upon any of these conditions. Second, a CSA program could reduce poverty and alleviate stress on families by ensuring a steady stream of income. Third, the CSA program could reduce the number of custodial parents requiring welfare support. A CSA program might not impose the high marginal tax rates that families experience under the current welfare system, thereby creating a work incentive for custodial parents.

During the last two years, at least six proposals for national or demonstration assurance programs have been offered in Congress. Child support assurance was also included in the final recommendations of the bipartisan National Commission on Children (1991).[2] To date, New York has been the only state to test a pilot assurance project, although a number of other states have considered the possibility.

This analysis uses the Urban Institute's Transfer Income Model (TRIM2) to estimate the costs of a hypothetical child support assurance (CSA) program given existing child support awards and payments. The analysis also examines the impact of the hypothetical program on poverty and family incomes. This research reviews earlier analyses of a CSA program and provides more recent estimates of its potential effects.

Previous Estimates of the Effects of a National Child Support Assurance Program

Previous research has examined the costs and effects of child support assurance. The most comprehensive study, to date, was conducted by Meyer, Garfinkel, Oellerich, and Robins.[3] This analysis applied microsimulation techniques to data from the 1986 Current Population Survey -

Child Support Supplement (CPS-CSS) to explore a range of alternative assurance programs and changes in child support outcomes.

One scenario restricted CSA eligibility to families with awards. The annual guarantee was $1,000 for one child, $2,000 for two children, $3,000 for three children, $3,500 for four children and $4,000 for the five children. This program taxed CSA benefits and reduced AFDC by the full amount of assurance received. The analysis simulated a labor supply response and incorporated into the cost estimate decreased tax revenues resulting from reduced work effort of custodial parents. Given 1985 levels of child support awards and collections, the estimated cost of the CSA program was $448 million, in 1985 dollars, net of changes in federal taxes and AFDC.

The research also examined an alternative scenario with higher guarantees of $2,000 for one child, $3,000 for two children, $4,000 for three children, $4,500 for four children, and $5,000 for five children. The net cost of this program was almost $1.8 billion, in 1985 dollars.

Another study estimated the costs of alternative CSA programs using data from the 1984 Survey of Income and Program Participation (SIPP) (Lerman, 1989).[4] One scenario in this analysis restricted CSA eligibility to families with awards. The annual guarantee level was $1,080 for one child and AFDC benefits were reduced by the amount of assurance received. The estimated cost of this program was $1.1 billion, in 1984 dollars, net of changes in AFDC benefits.

There are several limitations to the earlier estimates. First, neither analysis performed a thorough simulation of Aid to Families with Dependent Children (AFDC) using state-specific eligibility rules and benefit formulas. The Garfinkel estimates used state maximum payments and applied estimated tax rates on earnings to determine AFDC eligibility and benefits. The Lerman estimates used SIPP-reported AFDC benefits. In both cases, AFDC recipients and benefits were lower than reported by administrative data. Second, the estimates did not include offsetting changes in Food Stamp benefits, a potentially significant factor in determining a CSA program's net costs. Third, both sets of estimates assumed 100 percent program participation, that is, that all eligible families would apply for and receive assurance benefits. Thus, these estimates reflect an upper bound of program costs. Finally, more recent data sets capable of supporting CSA research have been released since the previous estimates were produced. These newer data reflect changes that have occurred in child support outcomes, AFDC benefit levels, and the demographic characteristics of the population.

Modeling a Child Support Assurance Program

This analysis examines the costs and effects of a hypothetical CSA program. Specifications of the hypothetical program are summarized in Table 1 and explained in more detail below. The program's design incorporates elements of several existing proposals; however, it is most closely patterned after the program recommended by the National Commission on Children and the demonstration project subsequently introduced in the U.S. Senate by Senator Rockefeller (S. 2237).

Table 1: Specifications of Hypothetical CSA Program

Program Feature	Hypothetical CSA Program Specifications
Eligibility:	o Families with Child Support Awards
Child Definition:	o Child with a Noncustodial Parent Eligible if: * < = 18 Years, or * < = 19 Years if full-time student
Means-test:	o None
Benefit Guarantee:	**# of Children** — **Annual Guarantee:** (1989 dollars) 1 — $1,500 2 — $2,500 3 - 8+ — $2,500, plus $500 for each additional child after 2
Recoupment:	o Recoup child support payments in excess of guarantee amount
AFDC Interaction:	**2 Alternative AFDC Interactions:** (1) AFDC Not Reduced (2) AFDC Reduced by 100% of Assurance
Food Stamp Rule Change and Interaction:	**Food Stamp Rule Change:** o Disregard CSA benefits and private child support income up to guarantee **Food Stamp Interactions:** o Food Stamp benefit changes resulting from AFDC interactions

In reality, an assurance program would most likely be enacted as part of comprehensive changes to the overall child support system, which could affect various support outcomes--the number of cases with paternity established, the number and amount of child support awards, and the number and amount of support payments. While improvements in these outcomes would have a direct and potentially significant impact on the costs of a national CSA program, the magnitude of such effects is uncertain. This analysis examines the impact of the hypothetical CSA program, assuming no changes in existing child support outcomes.

Eligibility Criteria. Eligibility for the hypothetical program is limited to families with child support awards. Children with a noncustodial parent are eligible for assurance if they are 18 or younger, however 19 year old children are eligible if they are full-time students. There is no means-test; all categorically eligible families and children are potentially eligible for a benefit, regardless of family income.

Benefit Levels. The model program's annual guarantees, in 1989 dollars, are $1,500 for one child, $2,500 for two children, and $500 for each additional child up to 8 children. In each month, a family's assurance benefit is calculated by subtracting the amount of child support received from the monthly guarantee. If the difference is greater than $10, the family is eligible to receive that benefit.

Recoupment. Several CSA proposals contain provisions for the government to withhold excess private child support to pay back assurance payments. This process is referred to as recoupment. Under this program feature, if a family receives an assurance payment in one month and later receives private child support, the government can recoup the excess private child support up to the amount of prior assurance benefits paid to the family. In the hypothetical program, excess child support available for recoupment is the amount greater than the monthly guarantee.

AFDC Interactions. The net cost of a CSA program varies by the treatment of assurance income for AFDC purposes. The Rockefeller demonstration proposed testing three different interactions between assurance and AFDC--reducing AFDC benefits by all, none or 50 percent of the assurance payment; different reductions would be implemented in selected sites.

The hypothetical program does not count assurance income in determining AFDC eligibility. However, the analysis considers two alternative treatments of assurance payments for calculating AFDC benefits. In one scenario, child support assurance serves as a supplement to AFDC. Thus, a family's AFDC benefit is not reduced when they receive child support assurance. In the second case, child support assurance benefits are treated as a substitute for AFDC income and AFDC benefits are reduced by the full amount of the assurance payment.

Food Stamps Rule Change and Interactions. This analysis includes two sources of change in Food Stamp benefits. First, the analysis models a change in Food Stamp rules to disregard private child support income up to the amount of the assurance guarantee. Currently, all child support payments are countable income in determining a family's Food Stamp eligibility and benefits.

Child support assurance would not be counted as income for Food Stamp purposes under the hypothetical program. The proposed Food Stamp change aims to ensure consistency between the treatment of child support assurance benefits and private child support payments. The child support income disregard would increase Food Stamp benefits of all households with child support income, including those families that do not receive assurance benefits.

The second source of change in Food Stamp benefits is caused by an interaction between the AFDC and Food Stamp programs. AFDC benefits are countable income in calculating Food Stamp benefits. Thus, a reduction in AFDC benefits results in an increase in Food Stamp benefits, although it is not a dollar-for-dollar relationship.

Data

The input file used for these simulations is a modified version of the March 1990 Current Population Survey (CPS), with demographic information as of March 1990 and income information for calendar year 1989. The CPS is a nationally representative survey conducted monthly by the U.S. Bureau of the Census. The sample includes about 57,000 households each month. The March CPS includes an "income supplement" to collect detailed information on income and labor force status in the prior calendar year.[5]

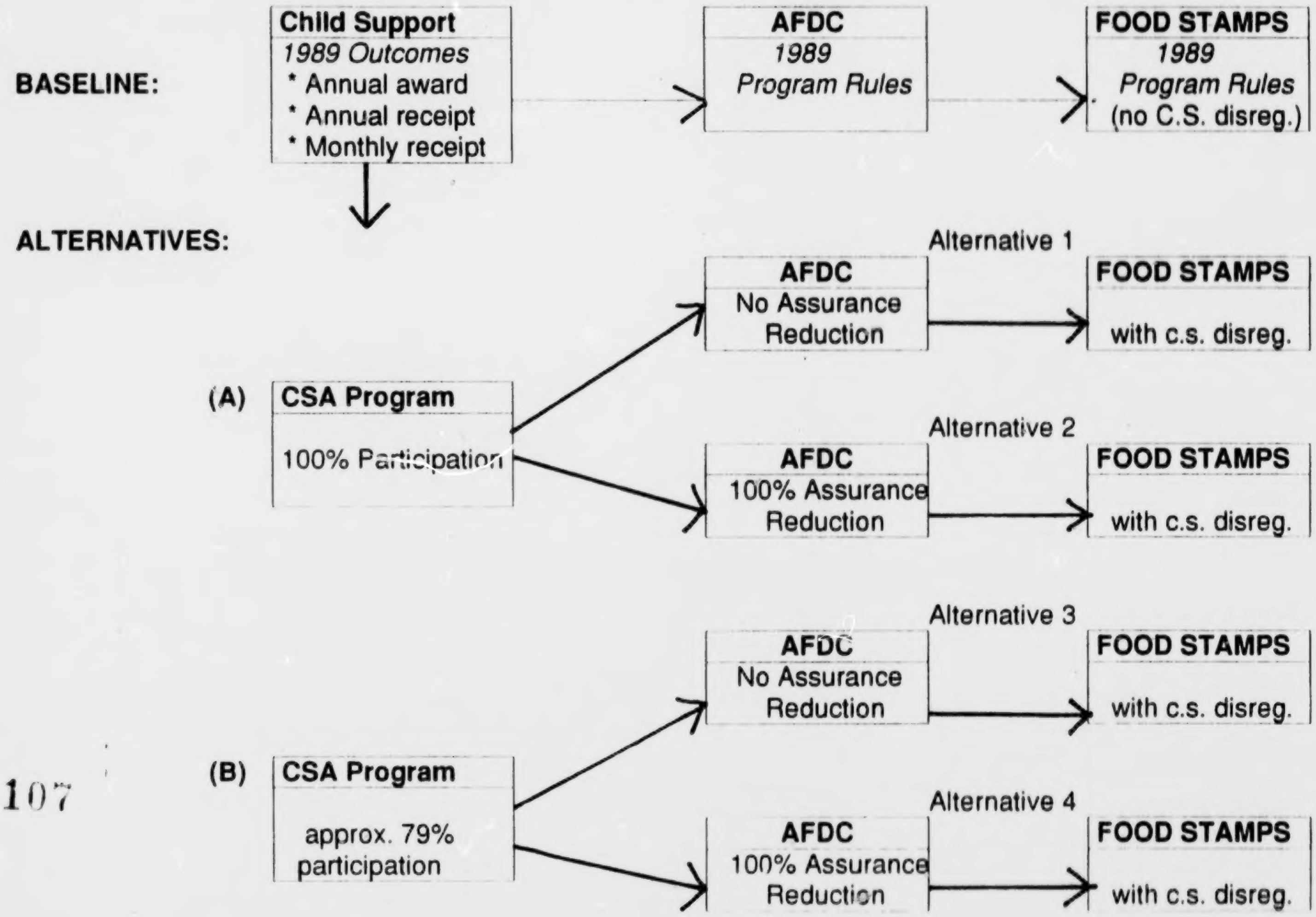
TRIM2 Microsimulation Model

The microsimulation model used to estimate the costs and effects of a national child support assurance program is called the Transfer Income Model, version 2 (TRIM2). TRIM2 is a comprehensive microsimulation model of tax and transfer programs, including AFDC, Food Stamps, the Earned Income Tax Credit (EITC), and federal income and payroll taxes. TRIM2 is divided into separate modules for each tax and transfer program, with each module holding a series of rules for that particular program. To simulate tax liability, or eligibility, participation and benefits for a program, TRIM2 applies the rules to each household in the March CPS file.[6] The Urban Institute recently expanded TRIM2 to have the capability of simulating proposals related to child support. Two modules were added--a child support module and a child support assurance module.

Description of Simulations

Two types of simulations are used to estimate the effects of proposed rule changes or, in the case of CSA, of establishing a new program: a baseline and alternatives. The "baseline" simulation applies actual program rules to the input file and serves as a benchmark against which alternative simulations are compared. Alternative simulations apply hypothetical or proposed rules to the input file. The simulated caseload and benefits under the alternative are compared to those in the baseline to assess the impact of the change. One baseline and four alternatives were simulated to examine variations of the hypothetical CSA program. These simulations are displayed graphically in Figure 1. The simulations are explained in more detail below.

Figure 1: Baseline and Alternative TRIM2 Simulations


BASELINE:
Child Support
1989 Outcomes
* Annual award
* Annual receipt
* Monthly receipt
AFDC
1989
Program Rules
FOOD STAMPS
1989
Program Rules
(no C.S. disreg.)
ALTERNATIVES:
Alternative 1
AFDC
No Assurance Reduction
FOOD STAMPS
with c.s. disreg.
(A)
CSA Program
100% Participation
Alternative 2
AFDC
100% Assurance Reduction
FOOD STAMPS
with c.s. disreg.
Alternative 3
AFDC
No Assurance Reduction
FOOD STAMPS
with c.s. disreg.
(B)
CSA Program
approx. 79% participation
Alternative 4
AFDC
100% Assurance Reduction
FOOD STAMPS
with c.s. disreg.

Baseline Simulation. To establish the baseline for this analysis, TRIM2 first defined the 1989 demographically-eligible child support universe. Demographically-eligible families are those consisting of a custodial mother living with her own children under 21 who have a noncustodial father. TRIM2 identified each demographically-eligible family in the CPS and then used a series of functions to impute whether the mother had a child support award, and whether she received any child support during the simulated year. The model also estimated the amount of the mother's award, and the amount of child support she actually received. TRIM2 divided the annual child support payments into monthly amounts using information from the SIPP. For each custodial mother, the model determined how many and which of her children have a noncustodial father.

Next, baseline AFDC and Food Stamp caseloads and benefits were simulated using 1989 program rules and the simulated child support amounts. Under current law, AFDC recipients must assign their child support rights to the State. Child support payments for these families are made to the state Child Support Enforcement (CSE) agency. The amount of child support income is used to determine whether the family is eligible for AFDC. If the family is eligible for AFDC, their benefit amount is determined excluding child support income. The family receives the first $50 of child support and the remaining child support is retained by the State to offset the cost of the AFDC program. In the Food Stamp program, child support income received is treated as countable income for eligibility and benefit purposes.

Baseline federal income and payroll taxes were also simulated using the 1989 rules. A more complicated approach was used to simulate baseline amounts of the Earned Income Tax Credit (EITC). The EITC was simulated using 1994 program rules deflated to 1989 dollars, in order to capture changes between the simulation period and 1994, the year in which a CSA could be implemented. Because the 1994 EITC is more generous than in 1989, this program could affect family income used in the distributional analysis.

Alternative Simulations. The alternative simulations applied the hypothetical CSA program's rules to each family in TRIM2's demographically-eligible child support universe. For each of the four simulations, CSA eligibility and benefits were simulated using the program rules outlined earlier. Then, the analysis considered two participation rate assumptions, that is, the number of eligible families who would actually apply for and receive benefits. The first alternative analyzed the program's effects under a 100 percent participation rate, assuming that all eligible families would apply for and receive benefits. These results provide an upper-bound estimate of the program's potential cost.

Previous research has shown that not all eligible families actually apply for benefits in various transfer programs; lower income families who are eligible for higher benefit amounts are more likely to apply for benefits. The second alternative varied program participation with family income and benefit amount, a more realistic assumption. This resulted in an overall participation rate of 79 percent. Each family's simulated CSA eligibility, participation and benefits under the two alternatives were used to simulate interactions with AFDC and Food Stamps.

AFDC eligibility and benefits were simulated using the amount of private child support payments received by each family, less the child support that was recouped by the CSA program. After each family's AFDC participation and benefits were determined, two interactions between CSA and AFDC were modeled. In the first case, assurance payments supplement AFDC income and a family's AFDC benefit is not reduced when they receive child support assurance. Under this scenario, AFDC program changes occur because private child support payments are reduced by recoupment under the CSA program. The second case treats child support assurance as a substitute for AFDC and reduces a family's AFDC benefit by the full amount of their assurance benefit.

Finally, Food Stamp eligibility and benefits were simulated for each alternative. Each Food Stamp simulation included the hypothetical rule to disregard private child support income up to the amount of the guarantee. The Food Stamp simulations used the modified AFDC benefit amounts and private child support payments less the amount recouped by the CSA program.

After simulating the baseline and alternatives, each family's income, taxes and simulated benefit amounts were added up to examine overall income and poverty status. The only income/benefit amounts that changed between the simulations were private child support, child support assurance, AFDC and Food Stamps. Federal income and payroll taxes, EITC and other sources of income were unaffected by the hypothetical CSA program or by changes in AFDC and Food Stamps. For these income sources, baseline amounts were used throughout the analysis.

Estimates of a Child Support Assurance Program

Baseline information on the demographically eligible universe is presented in Table 2. TRIM2 identified 11.4 million custodial mothers in 1989. These mothers had almost 19 million children under 21 who were eligible for child support. Nearly half of these families, 5.5 million families, had a child support award. On average, the annual award was $3,055. About 4.2 million families received child support payments in the prior year. The average annual payment for these families was $2,544.

The bottom half of Table 2 shows the number of demographically eligible families receiving AFDC and Food Stamp benefits. More than 3 million (28 percent) of the demographically eligible families were simulated to receive AFDC at some point during the year. On average, these families received $3,735 in annual AFDC benefits. About 3.2 million (28 percent) of the demographically eligible families received Food Stamp benefits. The average annual benefit for these families was $1,727.

Table 2
Baseline Child Support, AFDC and Food Stamp Characteristics of Demographically-Eligible Families

CHILD SUPPORT STATUS OF FAMILIES		Percent of Demographically Eligible
Demographically Eligible for Child Support Custodial Mothers (millions) Children < 21 (millions)	 11.4 18.8	 100%
Families with Child Support Awards (millions) Average Annual Award	5.5 $3,055	48%
Families Receiving Child Support Payments (millions) Average Annual Amount Received	4.2 $2,544	37%
AFDC STATUS		
Demographically Eligible Families Receiving AFDC During the Year (millions) Average Annual AFDC Benefit	 3.1 $3,735	 28%
FOOD STAMPS STATUS		
Demographically Eligible Families Receiving Food Stamps During the Year (millions) Average Annual Food Stamp Benefit	 3.2 $1,727	 28%

Source: Simmulations using the Urban Institute's TRIM2 model, based on the March 1990 Current Population Survey.

Note: Custodial mothers living with their own children <21 with a noncustodial father are considered demographicall eligible for child support.

Costs of a National Assurance Program

Table 3 shows the results of the four alternative simulations. The top half of the table shows the CSA program caseload and benefits under each participation assumption. The bottom half of the table shows the changes in AFDC and Food Stamp program costs under each alternative.

About 2.8 million families would be eligible to receive an assurance benefit in at least one month. Slightly less than 1 million of these families would experience recoupment of private child support payments in subsequent months. If all eligible families participated in the program, total assurance benefits would be $4.3 billion. However, $651 million of the costs would be offset by the recoupment of private child support. Thus, the net CSA cost would be $3.6 billion.

When program participation varies by family income and benefit level, approximately 2.2 million families, 79 percent of those eligible, are simulated to receive $3.4 billion in assurance benefits. About 725,000 of the participating families would experience recoupment in at least one month. A total of $486 million in private child support payments would be recouped to pay back the assurance program. The estimated net CSA costs would be $2.9 billion.

Under both participation assumptions, AFDC costs would increase if benefits were not reduced by assurance payments; this would occur because of recoupment. As previously noted, child support collected on behalf of AFDC recipients is currently used to offset AFDC costs. However, the hypothetical assurance program would recoup excess private child support to pay back assurance payments. As a result, AFDC recipients would have less child support available for AFDC purposes. TRIM2's AFDC benefits are net of the amount of child support collected by the CSE agency, that is, the benefits are the amount of AFDC the family actually receives less the amount of child support collected on that family's behalf. Thus, the lower child support amount available to AFDC after recoupment by CSA would cause an increase in AFDC costs. If AFDC benefits were reduced by the full amount of assurance received, AFDC costs would fall by approximately $1 billion. These results are similar for both the full and lower participation assumptions. This estimate provides an upper-bound of the amount that AFDC expenditures could be reduced under the hypothetical program.

Food Stamp benefits would increase under all of the alternatives. This is primarily the result of the new child support income disregard. The increase in Food Stamp benefits would be greater when AFDC benefits were reduced by the full amount of assurance payments. This would occur because AFDC is countable income in determining Food Stamp eligibility and benefits. The decrease in AFDC benefits would lead to an increase in Food Stamp benefits, although it is not a dollar-for-dollar offset.

The net cost of the hypothetical assurance program, taking into account associated changes in AFDC and Food Stamp costs, would range from $2.5 billion to $4.1 billion. The most costly alternative would occur under the program with full participation and no reduction in AFDC benefits for assurance payments. The least costly alternative assumes lower participation and a 100 percent reduction in AFDC benefits.

Table 3
Net Cost of Child Support Assurance Program

	100% CSA Participation		<Full CSA Participation	
	No AFDC Reduction	*100% AFDC Reduction*	*No AFDC Reduction*	*100% AFDC Reduction*
CHILD SUPPORT ASSURANCE				
Annual Caseload (000s)				
Annual Units Receiving Benefits	2,811	2,811	2,198	2,198
Units Experiencing Recoupment	962	962	725	725
Annual Costs (millions)				
Total Assurance Benefits	$4,256	$4,256	$3,417	$3,417
Total Child Support Recouped	$651	$651	$486	$486
Net Program Cost	$3,605	$3,605	$2,931	$2,931
AFDC				
Change from Baseline:				
Annual Program Benefits (millions) (net of the child support offset)	$36	($1,044)	$32	($962)
FOOD STAMPS				
Change from Baseline:				
Annual Benefits (000s)	$424	$555	$420	$534
NET COST (millions):	$4,065	$3,116	$3,383	$2,503

Source: Simulations using the Urban Institute's TRIM2 model, based on the March 1990 Current Population Survey.

Effects of a National CSA Program on Family Income and Poverty

Table 4 shows the distribution of assurance benefits by family income. In this table, families receiving assurance benefits are classified according to their baseline cash income, before taxes and transfer payments. The top half of the table shows the distribution of eligible families and their benefits by income group. The bottom half presents the results under the lower participation assumption.

Under both participation assumptions, families with incomes above 200 percent of poverty would comprise the largest group of CSA recipients. This occurs because higher income families are more likely to have awards, and, thus, would be eligible for the CSA program. While higher income families would have a lower average annual assurance benefit, this group would be eligible for the largest amount of the total benefits. Under the lower participation assumption, families with incomes above 200 of poverty would receive about a third of the total benefits.

It is interesting to note that a substantial number of very low income families, that is, those with incomes below 50 percent of poverty, would be eligible for benefits. This group would be eligible for almost one-third of the total assurance benefits. A large percentage of these families are simulated to receive benefits. The higher participation rate among this group results from the assumption that lower income families who are eligible for higher benefit amounts would be more likely to apply for benefits.

Table 5 shows the number of demographically-eligible families in poverty and the poverty gap under the baseline and four alternatives. The poverty gap is a measure of the amount of income required to raise all families' incomes up to the poverty level.

It should be noted that the results shown in Table 5 differ from those presented in standard published poverty tables in two important ways. First, the family definition used to produce Table 5 treats each subfamily as a separate family. Typically, published tables use a broader family definition that counts all related subfamilies together as one family.

Second, this table uses a more comprehensive income definition to determine family poverty status and to calculate the poverty gap. Usually, poverty status is determined based on a family's earned and unearned income. The results in Table 5 are based on an income measure that includes earned and unearned income, private child support payments, AFDC benefits, the value of Food Stamp benefits, CSA benefits, and the Earned Income Tax Credit, less simulated federal income and payroll taxes. When available, simulated income amounts are used; other income is based on March 1990 CPS-reported amounts. Simulated income amounts are preferred because they are corrected for under-reporting and/or are aligned to administrative totals. The broader income definition was used in this analysis to provide a better indicator of a family's economic well-being.

Table 4: Distribution of Child Support Assurance Recipients and Annual Benefits by Family Income

	FAMILY INCOME AS PERCENT OF POVERTY (1)						TOTAL FAMILIES (2)
	0-50%	50-94%	95-105%	106-149%	150-199%	200%+	
CHILD SUPPORT ASSURANCE Annual Caseload and Benefits							
Alternative A: 100% CSA Participation							
Number of Families (000s):	718	267	96	304	291	1,133	2,811
Average Annual Benefit:	$1,750	$1,701	$1,449	$1,552	$1,394	$1,346	$1,514
Total Annual Benefits (000s)	$1,257	$455	$140	$471	$405	$1,525	$4,256
Percent of Total	30%	11%	3%	11%	10%	36%	100%
Alternative B: < Full CSA Participation							
Number of Families (000s):	645	246	75	251	235	743	2,198
Average Annual Benefit:	$1,786	$1,721	$1,341	$1,579	$1,411	$1,358	$1,555
Total Annual Benefits (000s)	$1,152	$424	$100	$397	$332	$1,008	$3,417
Percent of Total	34%	12%	3%	12%	10%	30%	100%

Source: Simulations using the Urban Institute's TRIM2 Model, based on March 1990 Current Population Survey.

Notes: (1) Families are classified based on their baseline, pre-tax and pre-transfer, earned and unearned income. The baseline simulation used 1989 income and 1989 program rules, with the 1994 Earned Income Tax Credit rules deflated to 1989 dollars.

(2) Totals may not sum to 100% due to rounding. The totals also include a small number of families reporting negative income that are not included in the other columns.

Table 5:
Number of Demographically-Eligible Families in Poverty and the Poverty Gap Under the Baseline and CSA Alternatives

		100% CSA Participation		**<Full CSA Participation**	
	Baseline	*No AFDC Reduction*	*100% AFDC Reduction*	*No AFDC Reduction*	*100% AFDC Reduction*
Demographically Eligible Families (1)					
Number of Families in Poverty (000s) (2)	3,708	3,494	3,587	3,506	3,592
Change from Baseline (000s)		(214)	(121)	(202)	(116)
Poverty Gap (millions) (3)	$13,657	$12,186	$12,898	$12,294	$12,952
Change from Baseline (millions)		($1,471)	($759)	($1,363)	($705)

Source: Simulations using the Urban Institute's TRIM2 model, based on the March 1990 Current Population Survey.

Notes: (1) Custodial mothers living with their own children <21 with a noncustodial father are considered demographically eligible for child support.

(2) The income measure for families in poverty includes earned and unearned income, private child support payments, AFDC benefits, the value of Food Stamp benefits, Child Support Assurance benefits, and the Earned Income Tax Credit, less Federal income and payroll taxes.

(3) The poverty gap is the amount of money that would be required to raise all families' incomes up to the poverty level.

Using these definitions, there were 3.7 million families in poverty in the baseline; the baseline poverty gap was almost $13.7 billion. The rows of the table show the number of families lifted out of poverty and the reduction in the poverty gap under each alternative. At most, 214,000 families would be moved out of poverty by the hypothetical CSA program. The maximum possible reduction in the poverty gap would be about $1.5 billion. These results would occur if all eligible families participated in the program, and if families received assurance payments in addition to their AFDC income. Under the scenario in which fewer families participate in the CSA program, and AFDC benefits are reduced by the assurance payment, the program's effects on poverty would be smaller--only 116,000 families would move out of poverty and the poverty gap would decrease by approximately $700 million.

Conclusions and Areas for Further Research

This analysis suggests that if the objective of a CSA program is to reduce child poverty, the effectiveness of the hypothetical program is limited. For a cost of $4 billion, the hypothetical CSA program would reduce the poverty gap by about $1.5 billion. Only about 200,000 families living in poverty before the assurance program would have incomes above poverty after receiving assurance benefits. These outcomes would result only if all eligible families participate, and if there is no reduction in AFDC benefits. Assuming that fewer families participate and that AFDC benefits are reduced by the full amount assurance payments, the estimated program cost would be $2.5 billion. Under this scenario, only 116,000 families would be lifted out of poverty, and the poverty gap would decrease by about $700 million.

While this analysis provides comprehensive estimates of a CSA program's potential effects, there are several areas which warrant further research. First, alternative program rules should be examined to highlight those factors which have a significant impact on the program's costs and distributional effects. Future simulations should consider the effects of different eligibility criteria (both categorical and income eligibility), benefit amounts, interactions with AFDC, and taxation of assurance benefits.

Second, a CSA program would almost certainly be accompanied by changes in other features of the child support system, such as establishing paternity, determining awards, and collecting support. Thus, a range of sensitivity tests should be performed that alter the number of children with paternity established, the rate or amount of support awards and/or the number or amount of payments. Such an analysis would indicate the extent to which various policy measures to improve child support outcomes could affect the costs and effects of a CSA program.

Third, future analyses should examine behavioral responses to a CSA program. For example, in response to the implementation of a CSA program, some families may seek an award or increase their level of cooperation with government agencies to collect support payments. In addition, there may a labor supply response to this program. Custodial parents may reduce their work effort due to additional income from the assurance program. On the other hand, if the income is taxed at a lower rate than current welfare benefits, custodial parents may increase their work effort. Such effects should be considered in future estimates.

Finally, in order to more closely examine the effects of child support changes on family incomes and poverty, information on noncustodial fathers should be incorporated into distribution analyses. For example, increasing support collections, while raising the income of the custodial mother and her family, also lowers the incomes of noncustodial fathers and their families. This dynamic is not incorporated into existing studies of the effects of alternative child support policies.

Conclusions about the Hypothetical Program

- CSA program with 100% participation and no AFDC benefit reduction has the largest effects:

Cost	$4.1 billion
Reduction in Poverty Gap	$1.5 billion
Families Lifted Out of Poverty	214,000

- CSA program with lower participation and 100% AFDC reduction has the smallest effects:

Cost	$2.5 billion
Reduction in Poverty Gap	$0.7 billion
Families Lifted Out of Poverty	116,000

Factors that Could Affect the Conclusions

- Variations in Program Rules
    - Eligibility
    - Benefit Levels
    - Interactions with Other Programs
- Improvement in Child Support Outcomes
    - Increased Awards
    - Increased Collections

Notes

1. The numbers of women and children eligible for child support were produced by the Urban Institute's TRIM2 model. The number of families in poverty is based on a more narrow definition of "family" than is typically used in published poverty tables, therefore, the results are not exactly comparable to published numbers.

While the majority of children with a noncustodial parent live with their mothers, a significant number have other family arrangements. CPS data suggest that as many as 1.4 million fathers may have custody of their children. Children may also live with grandparents, or other relatives.

2. Beyond Rhetoric: A New American Agenda for Children and Families: Final Report of the National Commission on Children, 1991.

3. Child Support Assurance: Design Issues, Expected Impacts, and Political Barriers as Seen from Wisconsin, Irwin Garfinkel, Sara S. McLanahan, and Philip K. Robins, eds., The Urban Institute Press, 1992, pp. 159-188.

4. "Child Support Policies", Robert I. Lerman in Welfare Policies for the 1990s, Phoebe H. Cottingham and David T. Ellwood, eds., Harvard University Press, 1989. pp. 219-246.

5. Every two years, the April CPS collects detailed child support information in a child support supplement (CSS). Information from the March/April merged CPS files was used to estimate a series of statistical functions to impute detailed child support information onto the standard March file. These child support data are then used for other simulations, including AFDC, Food Stamps, and child support assurance.

6. More detailed information on the TRIM2 model can be found in An Analyst's Guide to TRIM2, Linda Giannarelli, The Urban Institute Press, 1992.

Non-Custodial Parents' Ability to Pay Child Support: Evidence from the 1990 Survey of Income and Program Participation

Elaine Sorensen, Ph.D., The Urban Institute

Noncustodial fathers' ability to pay child support is critical in today's policy debate about additional child support enforcement legislation, which requires noncustodial fathers to spend more of their incomes on child support payments. Despite considerable interest in strengthening child support enforcement, little is known about the ability of noncustodial fathers to pay child support. This study answers unanswered questions regarding the income and child support payments of noncustodial fathers. It also estimates the amount of child support that noncustodial fathers *could* pay given their existing income constraints.

For a copy of this paper, please contact the author (see address list).

Welfare Reform and Child Support

Wendell Primus, U.S. Department of Health and Human Services

This presentation provided the federal view of welfare reform and child support.

Job Opportunities and Basic Skills (JOBS)

Moderated by Dennis Putze
Pennsylvania Department of Public Welfare

JOBS Initial Evaluation of the Arizona Family Investment Initiative

Labor Market Analysis for the Family Investment Initiative (JOBS) - David Dorsey, Arizona Department of Economic Security

Impacts of the JOBS Program for AFDC Recipients in Ohio: Implications for National Welfare Reform - David J. Fein, Abt Associates, Inc.

Monitoring AFDC Participants' Progress through JOBS Components: An Examination of Statistical Techniques and Program Outcomes - Joseph P. Smyth, U.S. Department of Health and Human Services

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JOBS Initial Evaluation of the Arizona Family Investment Initiative

David Dorsey, Arizona Department of Economic Security

On October 1, 1990, the State of Arizona initiated the JOBS program which was the major component of the state's Family Investment Initiative. This evaluation focused on the first interviews with staff members and through management reports created by the JOBS computerized data base.

The evaluation scrutinized the implementation of the two JOBS employment and training program models: 1) JOBS-Basic, the program for single parents, and 2) the Two-Parent Employment Program (TPEP). Philosophy, participation requirements, client flow, and component activities were presented.

A special teen parent program, known as Young Families CAN, was also evaluated. Young Families CAN is a partnership between the City of Phoenix and the State of Arizona, and provides JOBS-Basic services to a special teen population.

Finally, the implementation of child care support service, which was a key component and guaranteed under the federal enabling legislation of the JOBS program was evaluated.

Selected findings of the report include:

1) The sanctioning process of reducing or eliminating AFDC payments for non-participation was inadequately implemented. There was no comprehensive effort to penalize JOBS clients who failed to participate.

2) TPEP, which was supposed to be both a program of employment and training, consisted of little more than directed job search.

3) Spousal participation in TPEP was much lower than anticipated.

4) JOBS staff were inadequately prepared and trained to implement the program.

5) The Community Work Experience Program, a component of the program that was to provide work experience to a large number of participants, was underdeveloped and only slightly used.

6) The Young Families CAN effort to provide JOBS services to teen parents was largely underutilized and ineffective.

For a copy of the full report, please contact the author (see address list).

Labor Market Analysis for the Family Investment Initiative (JOBS)

David Dorsey, Arizona Department of Economic Security

A labor market analysis of the JOBS program was conducted to determine the extent of congruence between the JOBS employment and training services provided to clients and the local labor markets in communities throughout Arizona. The study focused on three major labor market related issues:

1) the extent to which JOBS employment goals and job placements coincided with local projected and actual market demands and greatest occupational opportunities;
2) the effects of local economic conditions on JOBS participants and statewide participation; and
3) an examination of the utilization of employment related services to which clients were referred or were made available through the JOBS program.

Both quantitative and qualitative data were utilized in the study. The time period reflected was from the inception of the Arizona JOBS program, October 1990, through July 31, 1992.

The more significant findings include:

1) Overall, the JOBS program did a credible job of establishing employment goals and making placements for JOBS clients in employment areas that have sufficient opportunities.
2) The poor economic conditions that have existed statewide since the inception of JOBS have had a disproportionately negative impact on JOBS participants. However, it was not possible to accurately determine specifically the effect of local economic conditions on the *number* of JOBS participants.
3) The JOBS program was successful in establishing useful linkages with employment related resources throughout the state. In particular, the coordination with JTPA was good.

Job Opportunities and Basic Skills (JOBS)

Recommendations include:

1) Establish a formal mechanism to share employment related information among JOBS staff and employment research staff.

2) Better communication channels should be established within local offices to disseminate information about local trends and opportunities.

For a copy of the full report, please contact the author (see address list).

Impacts of the JOBS Program for AFDC Recipients in Ohio: Implications for National Welfare Reform

David J. Fein, Abt Associates, Inc.

Efforts under way to redesign the nation's welfare system will benefit from close scrutiny of current policies seeking to enhance recipients' economic self-sufficiency. Among the existing programs which merit such attention, the education and training, child care, and medical insurance provisions of the 1988 Family Support Act (FSA) are central. This presentation presents findings on the impacts of the FSA's employment and training program--JOBS--and ponders their implications for the broader welfare reform agenda.

Questions explored are:

1. To what extent has JOBS been successful in reducing welfare dependency and increasing employment and earnings? What is the time path for impacts, and what are the associated implications for limiting public assistance eligibility to a fixed interval of time?
2. What levels of program participation have been achieved, and how have rates of participation varied across program components such as job search, education and training, and community work experience?
3. Which program components appear to be associated with success?
4. What are the time periods required for success for different components, and what are the implications for time-limited welfare?
5. What is the role of supportive services and transitional benefits (e.g., Medicaid and child care) in facilitating employment?

Analyses were based on data from a rigorous evaluation of the JOBS program in Ohio, which, from January 1989 to December 1992, was home to one of the earliest JOBS group--required to participate in JOBS--or to a control group, which was neither required nor allowed to participate. This experimental design generates accurate estimates of overall impacts on program participation and employment outcomes. Estimates of the effectiveness of specific program components will be based on non-experimental methods.

The research draws on three data sources. Data on AFDC and JOBS participation are contained in a single file with records for each spell of AFDC eligibility and work program participation. Employment and earnings are measured using quarterly data from the state's Unemployment Insurance system. Analyses of these primary data were supplemented by survey data on demonstration participants' needs for and use of supportive services and transitional benefits.

For further information about this study, please contact the author (see address list).

Monitoring AFDC Participants' Progress through JOBS Components: An Examination of Statistical Techniques and Program Outcomes

Joseph P. Smyth, U.S. Department of Health and Human Services

The Job Opportunity and Basic Skills (JOBS) Training Program was created as part of the Family Support Act of 1988 to assist Aid to Families with Dependent Children (AFDC) recipients achieve an adequate level of self-sufficiency. The program contains the following significant characteristics designed to address specific issues that have impeded welfare clients from successfully engaging in self-development initiatives.

1) The JOBS program provides a wide range of services that allows state and local agencies the flexibility to develop client specific employability plans. The required skills training, job readiness training and job development and job placement assistance. In addition, states can optionally provide group and individual job search, on-the-job training, work supplementation and community work experience services, as well as post-secondary educational opportunities.

2) The JOBS program provides financial incentives to assure that AFDC recipient populations that are prone to adverse social and psychological factors and/or vulnerable to adverse economic conditions, including the young custodial parent with limited work skills and long-term recipients, are targeted for employment and training services.

3) The JOBS program provides guarantees that AFDC recipients receive the child care and other supportive services necessary for their participation in service components.

The presentation included an automated scheme that uses the JOBS Program Participation Data Collection Report, FSA-108, to track participants' progress through JOBS components. The approach should enhance the value of the FSA-108 information for states that complete the report for a 100 percent sample of JOBS participants. The primary objectives of the study are:

- Describe a Statistical Analysis System (SAS) program designed to track type of JOBS component activity, time of participation, gaps between component assignments, and intermediate and final component outcomes; and

- Examine statistical techniques for analyzing the relationship between selected demographic characteristics of the AFDC population and JOBS program variables and participation progress, including the impact of child care services on component outcome.

The SAS program extracts selected data elements from the state monthly FSA-108 file and creates a PC-based, integrated database consisting of three files containing component tracking, client characteristics and child care information. The paper presents findings based on actual FSA-108 reported information to the extent possible.

The scheme provides a logical approach for monitoring and analyzing JOBS program outcomes that takes into consideration the objectives of the JOBS program, characteristics of the AFDC population and quality of the FSA-108 data.

For further information about this study, please contact the author (see address list).

General Assistance

Moderated by Jeffrey J. Repichowski, M.A.
New Mexico Human Services Department

State of Arizona: 1992 General Assistance Program Evaluation - Jing Luan, Ph.D. and Ellen Konrad, Arizona Department of Economic Security

Termination of General Assistance in Michigan - Robert G. Lovell, Michigan Department of Social Services

AFIRM: An Effective Tool in Detecting Fraud and Eliminating Duplicative Aid - Curtis Williams, EDS

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State of Arizona: 1992 General Assistance Program Evaluation DRAFT

Jing Luan, Ph.D. and Ellen Konrad, Arizona Department of Economic Security

Arizona's General Assistance Program (GA) is a state-funded cash assistance program for low-income individuals who are unemployable due to physical, mental, and/or social disability. The program is administered by the Arizona Department of Economic Security (DES). The GA program has experienced rapid caseload growth and increased expenditures over the past few years.

In 1990, the DES Family Assistance Administration (FAA) conducted a GA caseload characteristics study based on case data collected from April through December 1989 on a random sample of GA clients. The study profiled the basic demographic and program participation characteristics of those GA recipients.

However, the recent and substantial increase in the GA caseload raises questions about the reasons for such growth and whether the nature and composition of the recipient population has changed. Therefore, the DES Office of Evaluation (OEV) of the Division of Administrative Services (DAS), has conducted a new study of the GA program to obtain current information about GA client and program participation characteristics, and trends in caseload growth.

This study consists of both quantitative and qualitative information on various aspects of the GA program in an attempt to answer several different research questions. This document contains the findings from an analysis of administrative data on a sample of 450 GA cases active in October 1992, and supplemental information obtained from valid interviews of 117 clients who were selected for Quality Control Reviews in the months of August, September and October. Qualitative information about the GA caseload and program operations was obtained from staff interviews conducted in October and November. In addition, the status of the department's efforts to convert appropriate long-term GA recipients to the federal Supplemental Security Income (SSI) program is assessed, and features of GA programs in other states that may be applicable in Arizona are surveyed.

General Assistance Client Demographic and Program Participation Characteristics

Overall, the characteristics of the GA population are largely similar to the characteristics of the population three years ago. Moderate to substantial shifts were found in the length of stay on GA, ethnic composition, disability type, and age. However, some of those changes may be attributed to differences in methodology and/or data sources between 1989 and 1992 studies.

Caseload	The average monthly number of GA recipients has increased from 5,106 in 1989 to 8,123 in 1992, an increase of 59%.
Benefit Payments	Currently, 75% of GA clients receive $173 monthly (which includes an allowance for housing costs). In 1989, 85% of GA clients had housing expenses requiring the higher payment level.
Length of Stay	As of October 1992, the average length of time on GA was seven months. Thirteen percent of the sample had been receiving GA benefits for more than 12 months; 36% had been receiving assistance for three months or less. This is a substantial Change from the 1989 study in which 39% were reported as having been on GA for over 12 months and only 11% for less than three months.

However, some of the shift may be due to different methods of calculating the length of stay used in the 1989 study.

Ethnicity The ethnic composition of the GA caseload as of October 1992 is: 73% White, 16% Hispanic, 5% Black, 2% American Indian, and 4% other. This reflects a modest shift from the 1989 ethnic mix: 62% White, 20% Hispanic, 12% Black, and 6% American Indian. The percentage of Whites has increased somewhat since 1989, with a corresponding decrease in the percentage of minorities. However, some of that shift may be due to differences in the reporting methods used in the 1989 study.

Age Both the mean and median age of the GA client is approximately 41 years. Sixty-six percent (66%) of GA clients are between 30-54 years old, a 6% increase in this age group from 1989.

Gender Approximately 61% of the GA population are males and 39% are females. That ratio has remained much the same since 1989, with a shift of 2% to slightly more males.

Education Twenty-four percent (24%) of GA clients from whom supplemental information was obtained had less than a 10th grade education. But over half of GA clients reported having received a high school diploma or GED. In 1989, over 40% of cases had no information on education level, making comparisons between the two years inappropriate.

Disability Thirty-four percent (34%) of the clients questioned reported that their primary disability was due to an injury, such as a fracture or broken back; 35% had medical/disease disabilities; 18% had a mental illness; and 9% were alcohol/drug dependent. This represents a slightly different composition of disability types than that found in 1989: 22% were reported as having injuries or fractures, 24% as having a mental illness, and 16% as being alcohol/drug dependent.

Employment Sixty-five percent (65%) of the clients surveyed reported not having been employed within the past 12 months, which is consistent with the 1989 study. Twenty percent (20%) had never worked.

SSI Forty percent (40%) of the clients surveyed indicated that they had applied for SSI before they applied for GA benefits.

Food Stamp Participation Eighty-seven percent (87%) of the sampled GA clients participate in the Food Stamp program. This is a decrease of 5% from 1989.

Summary of Staff Interviews

- Most FAA staff believe the poor economy has been the major reason for the increase in caseloads. Other reasons may include improved information dissemination about the GA program through community service organizations.

- FAA staff estimate that 20-30% of GA applicants are determined ineligible because they do not meet the disability criteria or because they fail to complete the application process.

- Staff describe the typical profile for a GA recipient as being a single white male, between the ages of 30-45, suffering from an injury. Overall, they do not think this profile nor the nature of the GA population has undergone any substantial change in the past 3-5 years, although they have noted an emergence of a small number of HIV cases.

- FAA staff estimate that approximately two out of ten clients (20%) are determined long-term disabled and are referred to the federal Supplemental Security Income (SSI) program. FAA staff believe that departmental efforts to convert potentially eligible GA applicants to the SSI program are worthwhile and should improve the rate of successful SSI approvals of those clients.

- Most FAA staff interviewed believe in the merits of the GA program i.e., providing temporary relief to truly disabled people who have no other sources of support. However, many of them suggested setting stricter policies regarding the eligibility of people who abuse alcohol and drugs. They would also like to see a requirement for GA clients to participate in job training programs as part of their obligation for receiving GA benefits.

Supplemental Security Income Conversion Initiatives

Eligibility Assistance

The department's primary SSI conversion initiative is a project to provide assistance (via a contracted community agency) to GA recipients with long-term disabilities in applying for and/or appealing denials of SSI benefits. DES began contracting in February 1992 in Maricopa and Pima Counties with Advocates for the Disabled, Inc. (AFD) for a pilot project to provide assistance, advocacy and support in the SSI eligibility determination process to GA clients.

Overall, AFD estimates that their GA cases take an average of 9 to 12 months to complete. The number of FAA referrals to AFD in FY 1992-1992 started slowly and rose to a cumulative total of 256 by the end of June 1992. After reaching a high of 414 active cases in June 1992, the "point-in-time" monthly caseload settled into the range of 300-350. During FY 1991-1992, approximately 71% (n=59) of the cases that were closed had won SSI approval (which includes both initial applicants and appeals).

Representative Payee Program

The federal Social Security Administration (SSA) suspends the SSI or Social Security benefits of persons whose abuse of alcohol or drugs or whose mental incapacity prevents them from managing their own finances, and who have no one else to do so on their behalf. In such cases, if a representative payee can be identified, SSA appoints that person to manage the benefits of the eligible recipient. If a representative payee cannot be found, the person may still be eligible to receive GA benefits.

For those cases, DES contracts through the Aging and Adult Administration with community organizations for representative payee services for GA recipients. Representative Payees establish financial accounts and records for the clients, visit them once a week, and if necessary, assist them with food, shelter, medical, clothing, utility, transportation and/or housekeeping needs, among others.

For the 13-month period of December 1991 through December 1992, the total number of GA recipients referred to Representative Payee contractors was 158. The total number of Representative Payee appointments made was 90. The total cost avoidance of GA benefits that would otherwise have been paid to those 90 recipients, less contractor costs, was $25,031.

Interim Assistance Reimbursement Agreement

A relatively new aspect of Arizona's GA program is the Interim Assistance Reimbursement Agreement (IAR) between the State and SSA. Effective July 1, 1992, SSA sends DES the retroactive benefits of newly SSI eligible individuals who had been GA recipients. DES deducts from their SSI benefits the amount paid in GA benefits and any attorney's fees from the appeals process, and distributes the remainder to the client. DES can recover benefits paid since July 1, 1992, as long as the GA recipient has signed a release allowing DES to do so. The amount deducted from the SSI payment for the GA benefit paid is on a month by month basis and it cannot exceed the SSI approved amount for a particular month.

From July 1992 through February 1993, a total of 239 cases were processed for Interim Assistance Reimbursement by DES and a total of $200,000 was retrieved from SSA payments. This amount does not include operational costs. DES projects that a total of $500,000 will be retrieved by the end of June 1993.

Lessons from Other States

General Assistance programs vary widely across the country since they do not receive federal funds. Each government unit that provides such a program determines its own eligibility criteria, benefits levels, length of time people may remain eligible for assistance, and all other program features. In order to learn about policies and practices in other states and localities that are most similar to Arizona's program, or that might be most useful for improving program operations in this state, the study examined 13 other General Assistance programs. The following program features were studied in detail:

Time-limited Benefits

Eleven of the 13 programs imposed some sort of time limit on receipt of GA benefits. Most of the time limits are set between 6 to 9 months in a twelve month period. Maryland is most similar to Arizona's newly enacted benefit limitation, allowing no more than 12 out of 36 months. Denver has the strictest time limitation--no more than 90 days, and some states target the time limitation on substance abusers. In general, budget shortfalls have been the driving force for time-limited benefits.

Extensions to Time-limited Benefits

Among the states/localities that have time-limited benefits, there are considerable variations with respect to granting extensions. The criteria for granting extensions range from fairly rigid to quite flexible. In some cases, extensions are granted only to a portion of the eligible population.

Self-Sufficiency, Treatment or Work Program Requirements

A number of states/localities require disabled GA recipients to participate in some type of treatment, self-sufficiency or work plan regardless of their ability to work, and several also make benefits contingent upon participation in mental health or substance abuse treatment, vocational rehabilitation, or employment-related programs. Of the states/localities studied for this report, 6 have self-sufficiency, treatment plan, or work program requirements for disabled or unemployable recipients.

Recoupment from Other Financial Sources

Some states/localities have established procedures to obtain reimbursement from programs or other sources for which the GA recipient may also be eligible, such as Unemployment Insurance (UI), Workers' Compensation (WC), inheritances, or tort cases in which the GA recipient is a victim and receives a financial award as the result of litigation. Currently, 4 of the states studied recover benefits from other sources to offset their GA payments. While those states reported that recovery from alternative sources is not very large, they consider it cost-beneficial enough to pursue.

RECOMMENDATIONS

1. Self-Sufficiency Plans. The Office of Evaluation (OEV) recommends that FAA consider developing self-sufficiency plans for GA recipients that would include participation in treatment, rehabilitation, education, training and/or employment-related activities. Use of such plans would support the philosophy that most recipients are capable of engaging in some type of activity that might increase and/or expedite their potential for employment, however limited that potential or that activity may be.

2. Review of Appropriate Use of Contracted Medical Services. OEV recommends that FAA consider: a) examining the current role, policies and procedures for using contracted physicians and District Medical Consultants when determining and validating qualifying disabilities; b) exploring methods of achieving greater uniformity and consistency among physicians in determining medical disabilities for the GA program; and c) reviewing the selection, contracting and monitoring procedures for DES-contracted doctors.

3. Cost-benefit Analysis of the Interim Assistance Reimbursement Agreement (IAR). OEV recommends that FAA consider conducting a complete cost-benefit study of IAR and its savings to the state at some point after the first fiscal year cycle of operation has elapsed.

4. Recoupment from Other Sources. OEV recommends that FAA assess the feasibility and desirability of recouping payments made to GA recipients from other programs or sources, such as Worker's Compensation, Unemployment Insurance, inheritances, and/or clients' liability lawsuits.

5. Increasing SSI Eligibility Assistance. OEV recommends that FAA consider funding an additional contractor position to accommodate the waiting list of GA clients needing assistance in pursuing the SSI application and/or appeals process.

6. Time-limitation Tracking and Follow-up. OEV recommends that FAA track and report on the number of clients who are subject to benefit termination due to the time limit, beginning in July 1994, using a cohort of GA recipients as a pilot. Further, OEV recommends that FAA conduct a follow-up study of clients subject to the termination requirements during the first one to two years after the new policy is in effect to determine how the time limit affects clients.

7. Improving Data Collection Efforts. OEV recommends:

   a) improvements in data collection and/or reporting be made in the Arizona Payment Information System (APIS) to improve MIS support for the GA program pertaining to client tracking and fraud prevention;

b) a more systemic effort be made by SSI conversion participants to collect client status and outcome information, specifically, a method of tracking GA referrals through SSI final determinations; and

c) reassess the content and format of the data reported by Advocates for the Disabled on GA clients they are assisting with the SSI eligibility determination process.

For a copy of the full report, please contact the authors (see address list).

Termination of General Assistance in Michigan: An Interim Report of the General Assistance Termination Project (First Year Report of the Cooperative Project)

Robert G. Lovell, Michigan Department of Social Services

The Cooperative Project

- Funded by
  - The University of Michigan
  - Western Michigan University
    - Office of Research and Sponsored Programs
    - College of Health and Human Services
    - School of Social Work
  - United Way of Van Buren County
  - Van Buren County Social Services Board
  - Michigan Department of Social Services

The General Assistance Termination Project

- Funded by a grant from the Ford Foundation
- Principal Investigators
  - Sherrie Kossoudji, University of Michigan
  - Sandra Danziger, University of Michigan
  - Robert Lovell, Michigan Department of Social Services

Who was served by General Assistance In March, 1991?

- Families financially eligible for AFDC, but failing another requirement
- Childless couples
- Single individuals
  - Earning less than $262/month, after disregards
  - Having less than $250 in assets (excepted: home, contents, and car worth under $1500)
  - In six locations, Job Start served those 18-25
    - Similar, except that participation in an employment training program was required

What benefits were available to single individuals in March, 1991?

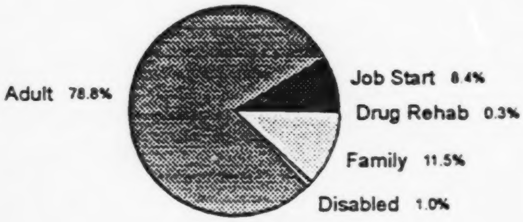
- Maximum cash grant of $262/month
  - By September, this had been reduced to $186/month
- Maximum Food Stamps grant of $105
- Together, these provided 59% of the poverty income level, down from 71% in 1982
- Help with some emergencies (utilities, rent deposits, home repairs, etc.)
- Medical coverage varying by location and age, but including outpatient and pharmacy benefits

Who were the GA recipients?

Adult GA Recipients by Category

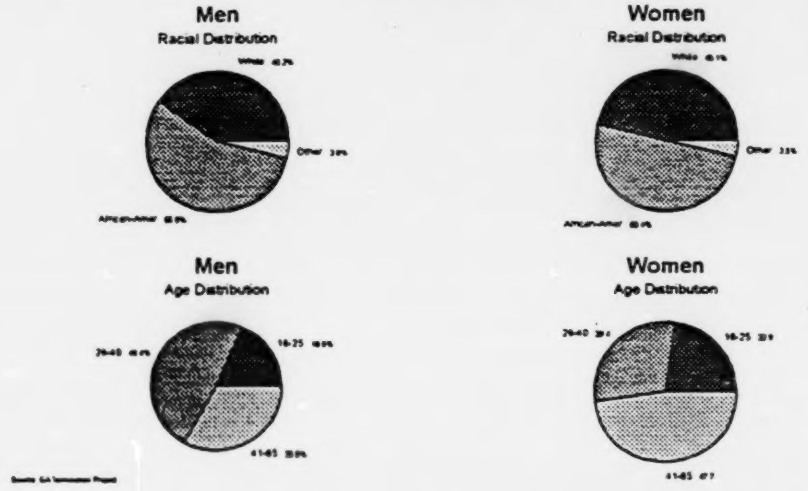
March, 1991

Total = 122,533 Adult Recipients



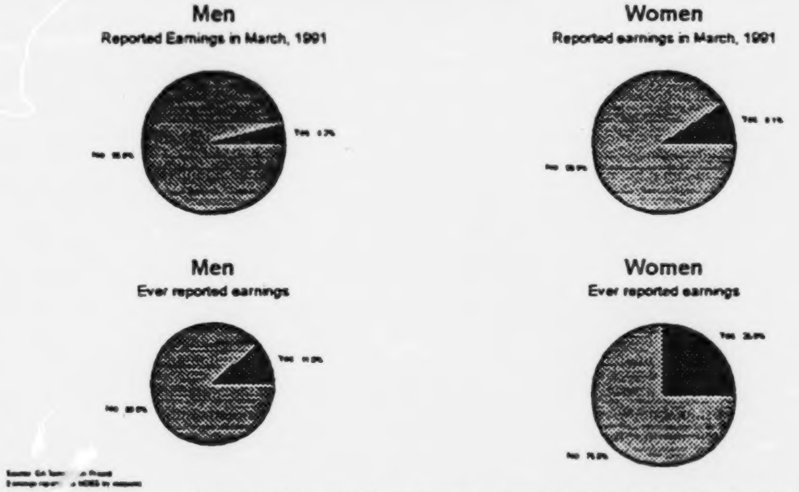
There were about 17,000 Children
Source: GA Termination Project

Who were the GA recipients? continued



March GA recipients who would lose benefits in Oct.

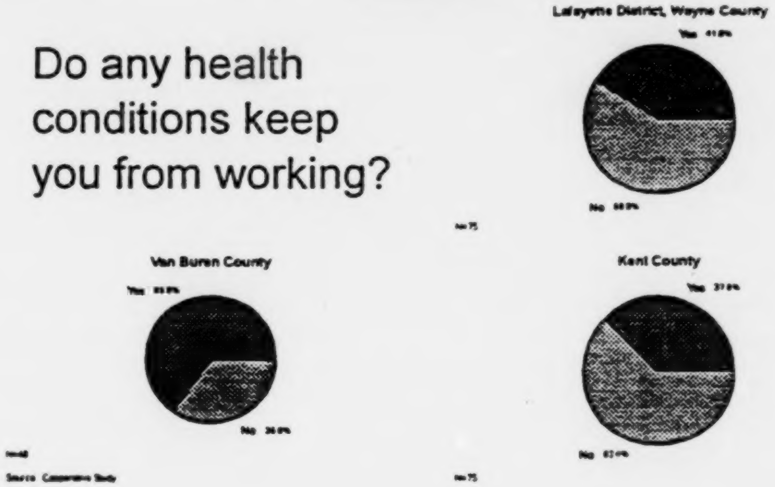
Who were the GA recipients? continued



March GA recipients who would lose benefits in Oct.

Who were the GA recipients? continued

Do any health conditions keep you from working?

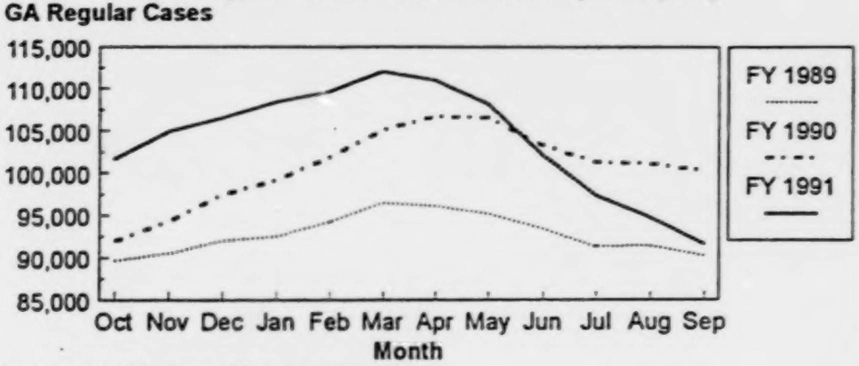


March - September, 1991

- In April, the Governor proposed that funding for childless adults who were not disabled end in May
- Court action by the Speaker of the House and others prevented this
- Although the Governor was eventually upheld, this action was made moot by later events
- This began a period of confusion for recipients

March - September, 1991

GA Regular Caseload Count Drops Rapidly



Includes Job Start Cases, GA Family Cases and
Cases later converted to State Disability Assistance
Source: Cooperative Study (Amended)

March - September, 1991 continued

- Grants were reduced for GA and for other programs, including AFDC (later restored)
- Debate on FY 1992 budget
  - FY 1991 budget deficit, $169.4 million, must be paid in FY 1992
  - Structural budget problems increase fiscal pressure
  - Atmosphere was partisan and acrimonious

March - September, 1991 continued

- Debate on FY 1992 budget continued
  - Governor proposed
    - Elimination of GA for non-disabled childless adults
    - A job training program with $100/month stipend, but not in budget
  - Democrats propose a required participation job training plan with stipend equal to GA
  - No bills to raise taxes are introduced by political leaders
  - In September, Governor's MDSS budget is enacted

What happened on October 1, 1991?

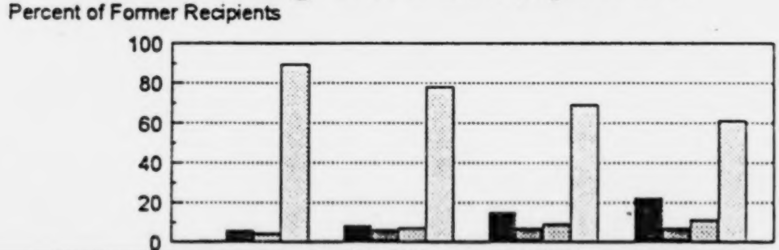
- Benefits for families with children continued through the State Family Assistance program
- Benefits for disabled adults not eligible for SSI continued through the State Disability Assistance program, although many had to reapply and prove disability
- Initial SDA caseload is 5,773
- GA is terminated with 10 days notice
- September, 1991 unemployment rates are 12.7% in Detroit and 9.1% statewide.

What happened on October 1, 1991, continued...

- Emergencies for childless adults were covered only when sufficient resources existed to prevent reoccurrence
- Medical coverage for childless adults was ended, but:
  - A limited program (Life Threatening Assistance) was begun almost immediately
  - The State Medical Assistance program was begun within two months, expanding shortly thereafter to approximate previous coverage
  - Wayne County residents never lost coverage

What happened to those who lost GA? Program Participation One Year Later

MDSS Program Participation

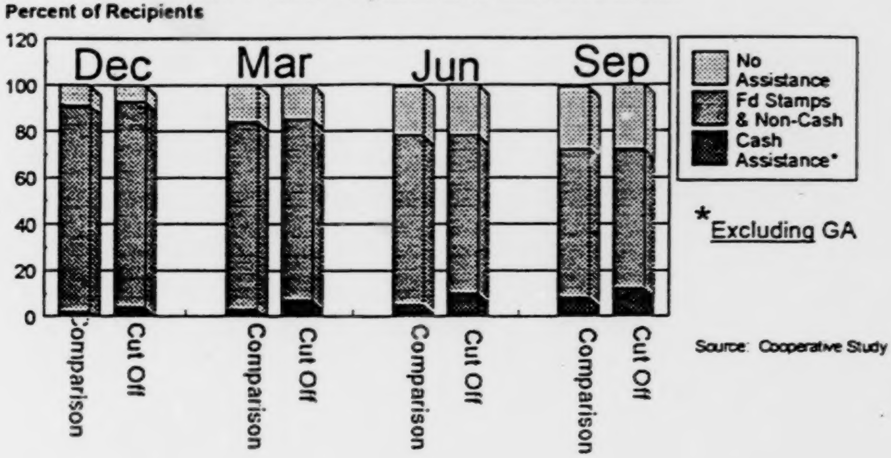


		Dec., 1991	Mar., 1992	June, 1992	Sept., 1992
No Asst., 3 Months	■	0.5	8.0	15.0	22.0
No Asst., 1 or 2 Mos.	▩	5.8	6.0	7.0	7.0
Cash Assistance	▨	4.3	7.0	9.0	11.0
Food Stamps & Non-Cash	□	89.4	78.0	69.0	61.0

Cash Programs: AFDC, SSI, SFA, and SDA
Non-Cash: Food Stamps, SMP, Medicaid-Only
Source: Cooperative Study/10% Sample

What happened to those who lost GA?
Program participation comparison

Similar FY 1990 GA Recipients Compared
With FY 1991 Recipients Who Lost GA Benefits

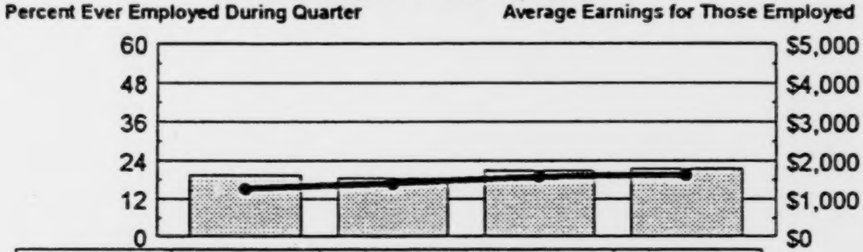


*Excluding GA

Source: Cooperative Study

What happened to those who lost GA?
Earned Income

Quarterly Employment Rates and Earnings
All Former GA Recipients



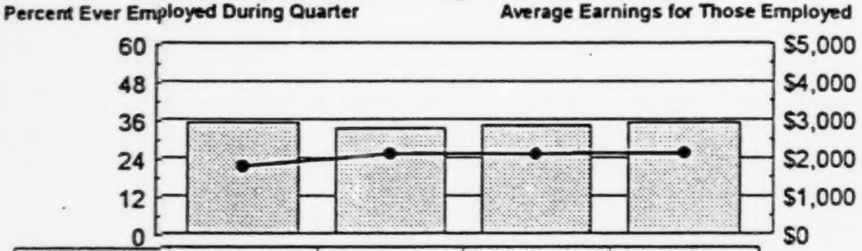
Quarter	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992
%Employed ▨	19	18	21	21
$Income ●	1,264	1,395	1,573	1,623

Source: Cooperative Study
Earnings reported to MESC

34% were employed at some time during the year.
Their average annual earnings were $3453.

What happened to those who lost GA?
Earned Income

Quarterly Employment Rates and Earnings
Ex-Recipients No Longer on Assistance

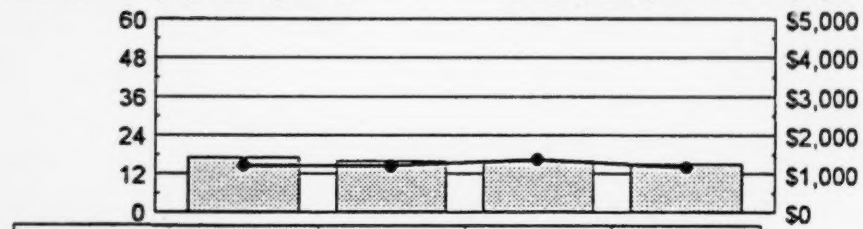


Quarter	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992
%Employed ▨	35	33	34	35
$Income ●	1,764	2,092	2,091	2,120

Source: Cooperative Study
Earnings reported to MESC

What happened to those who lost GA?
Earned Income

Quarterly Employment Rates and Earnings
State Medical Assistance Program Recipients



Quarter	Oct-Dec 1991	Jan-Mar 1992	Apr-Jun 1992	Jul-Sep 1992
%Employed ▨	17	16	16	15
$Income ●	1,227	1,203	1,374	1,168

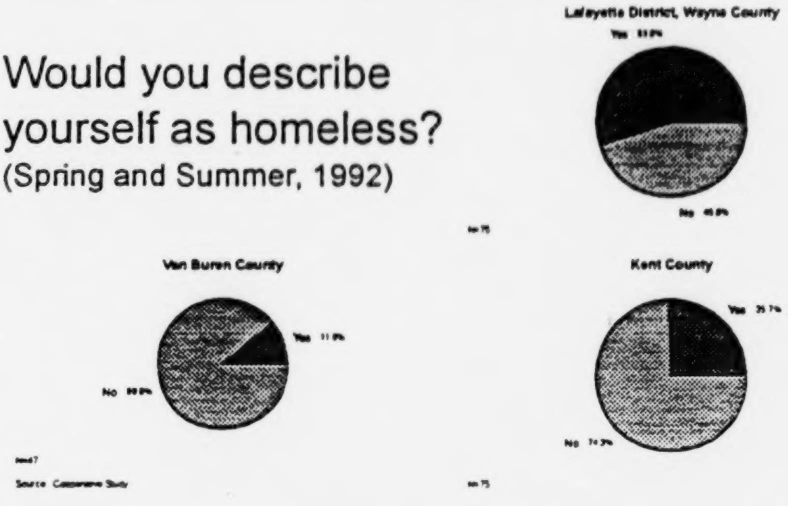
Source: Cooperative Study
Earnings reported to MESC

What happened to those who lost GA? Continued...

- The October, 1991 unemployment rates were:
  - 13.0% in Detroit
  - 9.0% in Michigan
  - 6.9% nationally
- The May, 1993 unemployment rates were:
  - 12.6% in Detroit
  - 7.0% in Michigan
  - 6.9% nationally
- 6,062 people received State Disability Assistance in October, 1991
- 8,789 people received State Disability Assistance in May, 1993

What happened to those who lost GA? continued

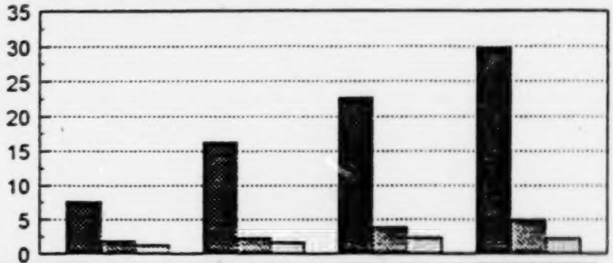
Would you describe yourself as homeless?
(Spring and Summer, 1992)



Source: Cooperative Study

What happened to those who lost GA? Recipients* Who Moved

Percent of Recipients Moving During Quarter (Cumulative)



Sample size 1000+	12/31/91	3/31/92	6/30/92	9/30/92
New Street Address ■	7.6	16.3	22.7	29.7
New City ▩	1.8	2.3	3.8	4.9
New County ▨	1.2	1.7	2.3	2.2

1% of cases use a MDSS office as an address

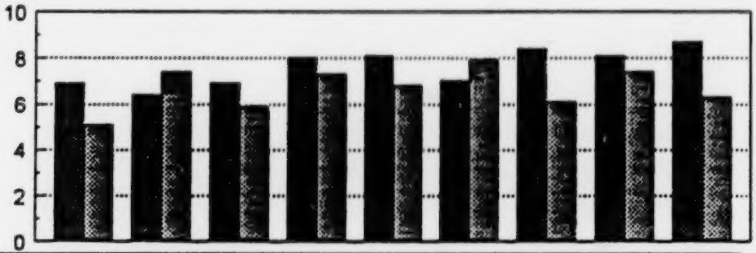
*Limited to those receiving other benefits.

Source: Cooperative Study

63.2% of former recipients did not move in the first year, or returned to their original address.

What happened to those who lost GA? Unadjusted Monthly Death Rates

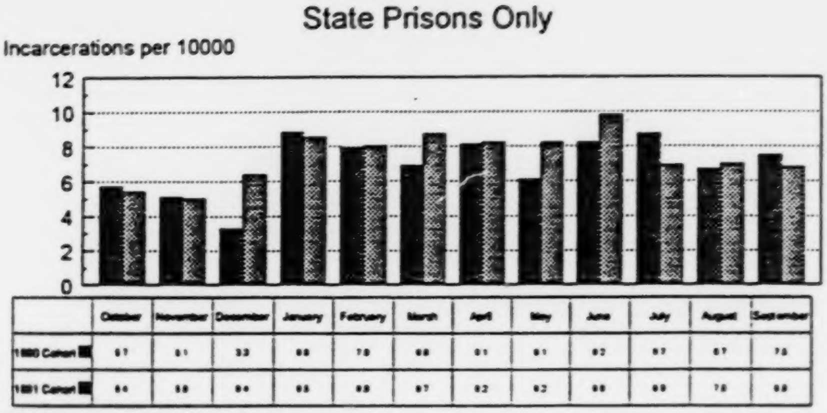
Deaths per 10000



	October	November	December	January	February	March	April	May	June
1990 Cohort ■	6.9	6.4	6.9	8.0	8.1	7.0	8.4	8.1	8.7
1991 Cohort ▩	5.1	7.4	5.9	7.3	6.8	7.9	6.1	7.4	6.3

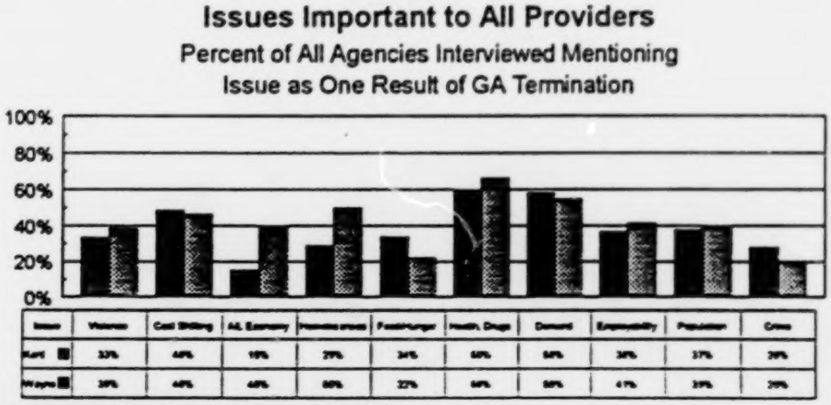
Rates for each cohort begin with October of the cohort year.
Source: Cooperative Study

What happened to those who lost GA?
Monthly Incarceration Rates

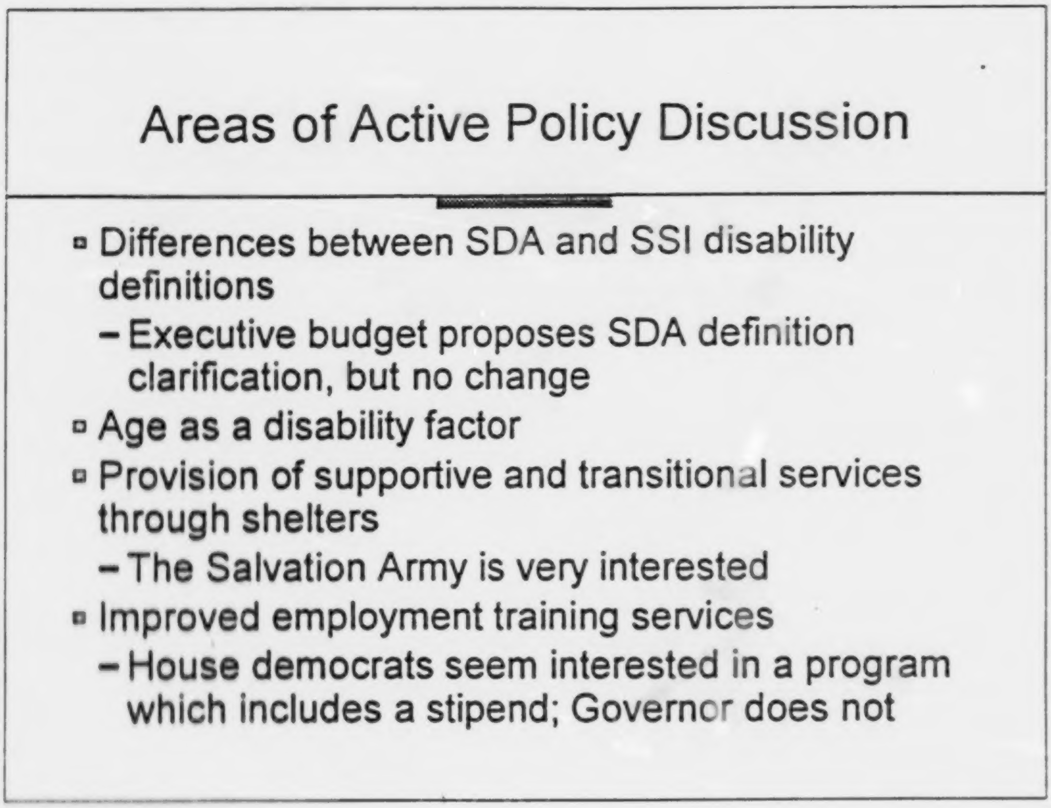


Rates for each cohort begin with October of the cohort year.
Source: Cooperative Study

What happened to those who lost GA?
Impacts on Local Service Providers



Based on 48 interviews in Kent County and 70 interviews in Wayne County completed in Spring, Summer and Fall, 1992.



Areas of Active Policy Discussion

- Differences between SDA and SSI disability definitions
  - Executive budget proposes SDA definition clarification, but no change
- Age as a disability factor
- Provision of supportive and transitional services through shelters
  - The Salvation Army is very interested
- Improved employment training services
  - House democrats seem interested in a program which includes a stipend; Governor does not

For a copy of the full report, please contact the presenter (see address list).

AFFIRM: An Effective Tool in Detecting Fraud and Eliminating Duplicative Aid

Curtis Williams, EDS

BACKGROUND

Los Angeles County's Department of Public Social Services (DPSS) is responsible for the administration of the General Relief (GR) Program which provides financial assistance to indigent who are not eligible for federal or state assistance programs. It also provides emergency assistance to individuals and families in temporary need.

Section 17000 of the Welfare and Institutions Code of the State of California mandates each county to have a General Relief Program. The cost of the program is borne entirely by the counties.

The GR Program is administered from 14 GR district offices throughout Los Angeles County servicing a near constant yet steadily growing GR caseload of more than 85,000 cases per month. As many as 19,000 GR applications are processed in a given month and approximately 80% of these applications are from repeat clients who were at some time previously aided on GR.

In May 1986, DPSS began fingerprinting and photographing GR homeless applicants without identification in the six major GR districts as an attempt to deter fraud and eliminate duplicate aid. Welfare Fraud Investigators from the Welfare Fraud Prevention & Investigations (WFP&I) Division were out-stationed to handle this manual (ink and roll) process. In three smaller GR district offices, Eligibility Workers or Eligibility Supervisors performed this task. (Welfare and Institutions (W&I) Code Section 17001 and County Code Section 2.102.050 B. allows for fingerprinting and photographing of both applicants and recipients as a condition of aid.)

Because of the increasing number of applications and the transitory nature of the GR client, the manual system became cumbersome and inadequate to search and match the more than 50,000 fingerprint/photograph cards on file at WFP&I, and act as an effective tool in deterring fraud and eliminating duplicate aid.

In July 1988, the Department's Automation Steering Committee established a Fingerprinting Sub-committee to cost out and determine the feasibility of an automated fingerprint system for the GR Program. The Sub-committee developed several concepts on how an automated fingerprint system could work for DPSS and solicited informal ball park estimates for each of the concepts from the vendor community. After reviewing the cost estimates provided by the vendors, the committee determined that an automated fingerprint system was indeed feasible for the GR Program.

Since this would be the first automated fingerprint system in the nation, outside of law enforcement, and because of the technical nature of the proposed system, the committee recommended that the Department acquire an independent consultant to conduct a feasibility study and assist in evaluating and writing the highly technical requirements for an RFP. The Department approved of this recommendation and negotiated a contract with George Warfel, an independent consultant. The money budgeted to acquire Mr. Warfel was well spent. His expert advice enabled us to achieve our desired results.

On May 16, 1990, DPSS released a Request for Proposals (RFP) to solicit proposals from qualified vendors to develop, install, operate and maintain an Automated Fingerprint Image Reporting and Match (AFIRM) System that met DPSS' hardware and software requirements. The RFP required:

- Contracting with a single vendor to supply all system software, hardware, training and ongoing operation and maintenance of an on-line AFIRM network.

- Four cost options for a 5 minute, 15 minute, 1 hour and overnight match/no match response printout.

- The system be ready for use by DPSS to accept and process fingerprints and case data for the intake and approved caseloads in three pilot district offices, followed by Countywide implementation two months later.

DPSS received three bids/proposals in response to the RFP. Responding vendors included EDS Federal Corporation (EDS), North American MORPHO Systems (MORPHO), and NEC Information Systems, Inc. (NEC).

On October 23, 1990, DPSS entered into a five-year contract with EDS Federal Corporation to supply all software, hardware, training and ongoing operation and maintenance for an Automated Fingerprint Image Reporting and Match (AFIRM) System for its General Relief Program. AFIRM has automated the manual process via live scan capture of two index fingerprints and matches the prints against a database to determine whether a client is currently receiving GR benefits in Los Angeles County.

On February 26, 1991 a three-year contract was awarded to PDQ Personnel Services for skilled clerical staff to provide terminal operator services for the AFIRM system. The clerks received two full days of classroom training by EDS personnel that included "hands on" instruction on how to operate the system and successfully perform their job tasks. EDS continues to support the clerks via a Help Desk (Hotline) function.

SYSTEM DESIGN

EDS has combined the software technology of Cogent Systems, Inc. and the hardware capabilities of Hewlett-Packard in its system design. AFIRM consists of a confidential database housed at EDS' central location in Los Angeles with remote workstations located in all 14 of the GR district offices, Welfare Fraud Prevention and Investigations (WFP&I) and Computer Services Division (CSD). The workstations at the district sites and CSD consist of a system processing unit, 16" color monitor, keyboard, mouse, printer, modem and two optical scan fingerprint readers. The workstation at WFP&I consists of a system processing unit, 19" color monitor, keyboard, mouse, modem and laser printer for specialized functions of viewing and printing fingerprint images. A dedicated telephone line is required at each site. CSD tests modifications to the system, monitors ongoing operations and generates any on-line reports that may be required.

The district offices, CSD, and WFP&I, access the system via Hewlett-Packard (HP) Apollo 9000 Model 400t workstations. The central site also houses Model 400t workstations to test system modifications and conduct training sessions. The workstations are connected through 9600 baud dedicated telecommunication lines to HP Apollo 9000 Series 800 Model 822S front-end processors.

The demographic information and the fingerprint minutiae data are stored as part of the Informix database management system on the file server. Connected to the file server is an HP Series 6300 Re-writable Optical Disk Library System, which provides cost-effective storage for the large-sized grey scale images. Through a local area network (LAN), the file server communicates to the HP Apollo 9000 Model 433S processors or matching engines. The fingerprint minutiae to be matched from the district offices are received by one of the front-end processors.

To ensure that all fingerprint matches have been identified in the event of incorrect demographic data (since the file is separated by male and female), AFIRM conducts a weekly open search of the fingerprint database. The open search matches each new fingerprint to every fingerprint in the file, limited to right against right and left against left. A weekly report is generated identifying any matches found. This helps to confirm system accuracy.and document the validity of the matches found on-line.

INTERFACE WITH CASE DATA MANAGEMENT SYSTEM (CDMS)

AFIRM provides for a daily one-way interface from CDMS. CDMS is DPSS' production system supporting GR cases. The CDMS/AFIRM Interface provides a means of updating AFIRM with demographic case data updated to CDMS for case and person status. A bi-monthly reconciliation also provides for a case by case match between AFIRM and CDMS to resolve any discrepancies between the two systems.

COST/BENEFIT

The cost of the $9.6 million dollar system is borne entirely by Los Angeles County. Innovation funding was provided in the DPSS' 1990-91 budget for development, testing and four months of system operation. Ongoing cost of operation and support for the remaining four years is budgeted based on an estimated number of fingerprints to be searched, matched and stored in the database and system enhancements and modifications.

Clearly the system is cost-effective. The amount of aid savings solely attributable to AFIRM through the end of December 1991 is $5.4 million. This was realized by terminating 3,021 approved cases and denying 242 cases for failure to comply with AFIRM requirements.

TIME FRAME

AFIRM was implemented in three pilot test districts, CSD and WFP&I on June 3, 1991, followed by a Countywide phase-in for the remaining eleven GR districts effective July 1, 1991. All 14 GR district offices were operational by July 15, 1991.

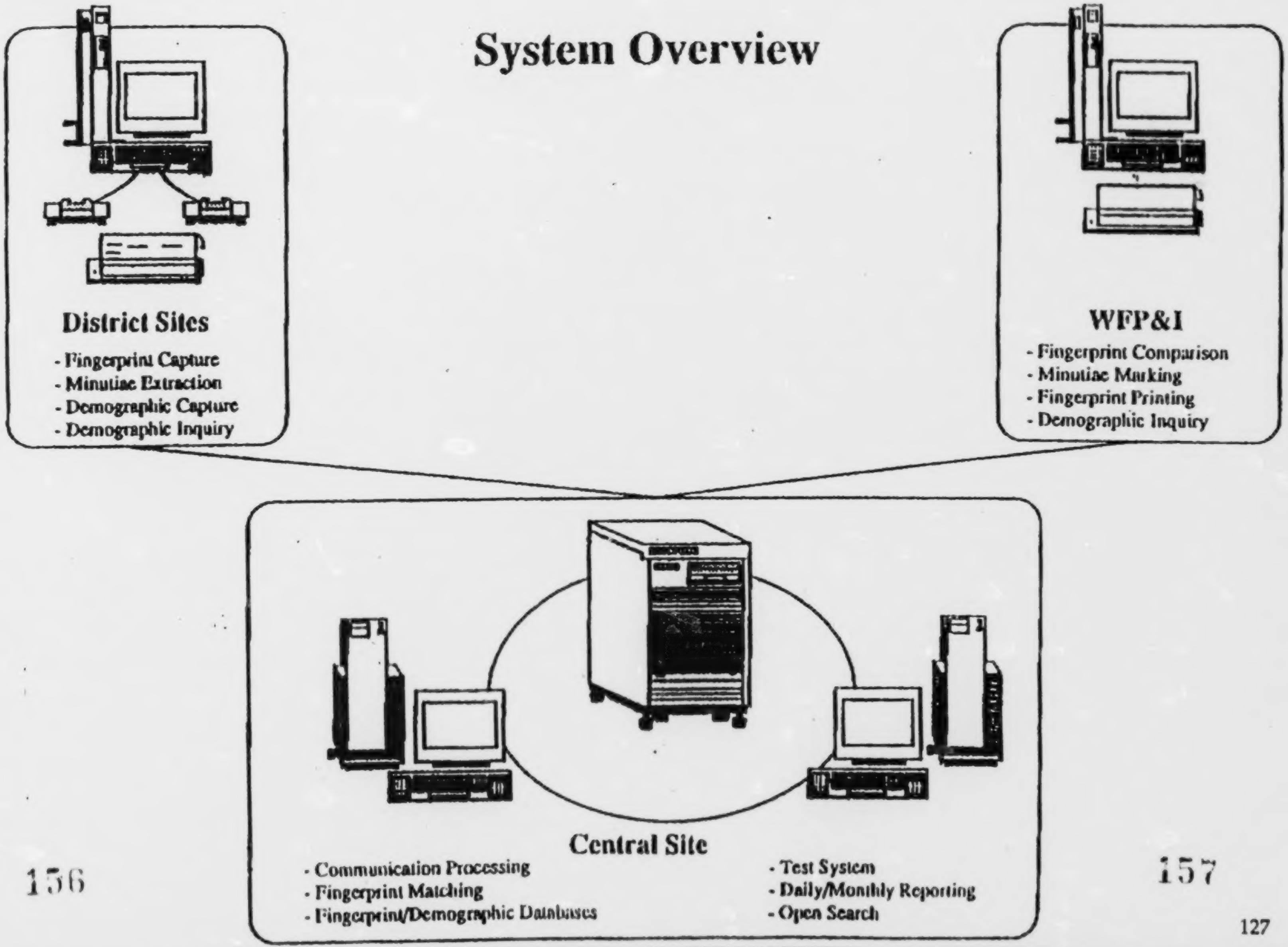
PUBLIC REACTION

AFIRM has been well received by the public and staff alike. They appreciate the fact that the new system will deter fraud, eliminate duplicate aid and ensure that benefits are issued only to eligible clients. Clients have accepted the new system and are very cooperative with the fingerprint clerks.

RESULTS

Results have been impressive. Manual searches that once took months to conduct are now expedited in minutes. Reports that used to take several weeks to compile can now be printed within hours. AFIRM has drastically improved our fingerprint processing capabilities as the average client can be processed in five minutes. We have also seen a reduction in paperwork and improved efficiency. Employees have been freed from tedious and often futile tasks of manually searching and matching fingerprint cards and have become more productive in other areas. Unlike the previous manual system, we no longer worry about a backlog of paper work. AFIRM has resulted in a more modern and efficient approach to our fingerprint process by managing the task more efficiently and easily. We pride ourselves in our ability to improve our service to the public through the use of this new area of technology.

System Overview

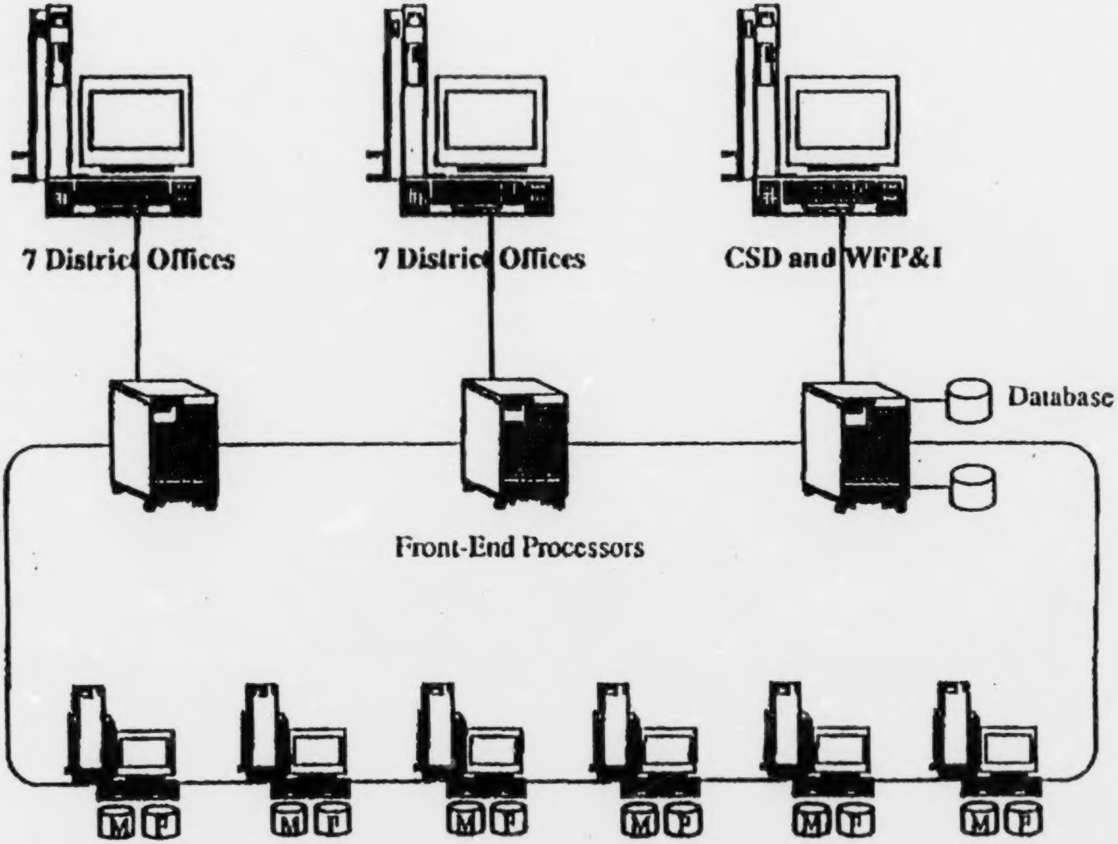


District Sites
- Fingerprint Capture
- Minutiae Extraction
- Demographic Capture
- Demographic Inquiry

WFP&I
- Fingerprint Comparison
- Minutiae Marking
- Fingerprint Printing
- Demographic Inquiry

Central Site
- Communication Processing
- Fingerprint Matching
- Fingerprint/Demographic Databases
- Test System
- Daily/Monthly Reporting
- Open Search

Central Site Hardware



7 District Offices

7 District Offices

CSD and WFP&I

Database Tables

Front-End Processors

Matching Engines

Welfare Reform II

Moderated by Joseph S. Golden
Wyoming Department of Family Services

New Opportunities, New Responsibilities: Welfare Reform in Wyoming - Mark W. Lusk, Ph.D., Boise State University, Joseph S. Golden, Wyoming Department of Family Services, Joseph D. Nies, Wyoming Department of Family Studies, and Martha S. Williams, Ph.D., University of Wyoming

Focus Group Process and Results: What Clients Have to Say about Welfare Reform - Cynthia Dennis, Delaware Health and Social Services

Washington State Refugee Self-Sufficiency Initiative - Thuy Vu, Ph.D., Washington Division of Refugee Assistance

The Maryland Model (Perspectives, Price, Partnerships, Problems, and Policy)
Richard E. Larson, Maryland Department of Human Resources

BEST COPY AVAILABLE

New Opportunities, New Responsibilities: Welfare Reform in Wyoming

Mark W. Lusk, PhD, Boise State University, Joseph S. Golden, Wyoming Department of Family Services, Joseph D. Nies, Wyoming Department of Family Studies, and Martha S. Williams, PhD, University Wyoming

> *"It is important for society to send a clear message, and workfare sends it. Good welfare policy must involve reciprocal obligations." S. Butler & A. Kondratas, Out of the Poverty Trap: A Conservative Strategy for Welfare Reform (1987). p. 145.*

> *"We've got to break the cycle of dependency and put an end to permanent dependence on welfare as a way of life. Our administration will do this by providing welfare recipients with the means, the incentives, and the requirement to go back to work. Welfare should be a second chance, not a way of life." Clinton Gore Campaign Statement on Welfare (1992). p. 1.*

> *"Our tendency to reward failure has literally crippled our efforts to help the poor. Most of the money we spend on the poor - welfare, food stamps, Medicaid, public housing, etc.- rewards failure because it goes only to those who remain poor." D. Osborne & T. Gaebler, Reinventing Government (1992). p. 149.*

In December, 1992, Governor Mike Sullivan proposed an experiment in welfare reform for the State of Wyoming. Noting the rapid rise in the state AFDC caseload, erosion of public support for traditional welfare programs, and limited state revenues, he proposed a reform strategy that is designed to promote self-sufficiency, stem caseload growth, and reduce welfare dependency. The Governor's proposal, subsequently enacted as law in early 1993, reflects an accelerating national trend by state governments to redefine the welfare contract by changing its emphasis from public assistance to self-sufficiency.

The Welfare Reform Debate

P.T. Bauer contends that, "...in politics, myth is all" (1981, p.1). No set of social policies in America has generated as much debate as welfare reform; much of it has been based on myth and ideology. Only recently has it been possible to pierce the ideological haze. Two factors account for the change. First is the provision of the Family Support Act of 1988 which allows for state waivers to federal program requirements permitting state governments to experiment with AFDC programs. This bill, which received broad bi-partisan support, has resulted in dozens of state waivers and experiments which have completely altered the traditional incentive structure of public assistance and changed the terms of the welfare reform debate. Many such experiments have incorporated reciprocal contracts between clients and agencies such as workfare, training, and community service.

A second factor making it easier to go beyond the ideological level in the welfare reform debate is the proliferation of scientific studies which objectively evaluate reform programs. Now it has become possible for state governments to learn from each other which program designs are most effective in pursuing a goal which constituents from all sides of the ideological debate seem to agree is a reasonable aim of social welfare programs: the promotion of client self-sufficiency.

The Policy Context

Although there is widespread agreement about the **ends** of public assistance, until recently there has been little consensus about the **means**. At one extreme are those who have contended that public assistance is a "right" of citizenship (Marshall, 1981), that the role of social workers and economic assistance workers is to assert that it is **government's** responsibility to assure a minimum standard of living for its citizens (Nichols-Casebolt & McClure, 1989), and that welfare programs, especially workfare, are designed for failure in order to support capitalism, patriarchy, and white supremacy (Miller, 1989). Most from this school of thought see welfare as an entitlement which should be much better funded and should involve no reciprocal obligation by the recipients (DiNitto, 1993). It is also argued by proponents of this approach that welfare reform, especially workfare, is fraught with problems and bound to fail because it does not address the true basis of poverty (Segal, 1989; Abramowitz, 1988).

Those at the opposite end of the ideological continuum assert that public assistance, rather than providing for the poor, has actually increased poverty (Mead, 1986) and that the poor are so because of a set of social pathologies including an absent work ethic, lack of aspiration, single parenthood, drugs, and crime (Rector, 1992). Within this school of thought are those who advocate for a complete dissolution of the welfare state (Murray, 1984) and others who think that public assistance should be a large scale behavior modification program to correct "behavioral poverty" (Rector, 1992).

In the decades of the 1960's and 1970's, social policy tended to be closer to the first pole than the latter. During the War on Poverty period in particular, programs were designed under the assumption that the poor were so due to circumstances beyond their own control. Liberal poverty policy sought to address the structural basis of indigence through community development programs (e.g. Small Business Administration, Office on Economic Opportunity), while ameliorating family poverty with unconditional grants-in-aid. The conservative revolution of the 1980's reversed the trend and social policy approximated the views of the latter pole by emphasizing traditional values of reciprocity, productivity, work, and family (Karger and Stoesz, 1990). It was asserted that government welfare programs acted as a disincentive to both work and family cohesion (Butler and Kondratas, 1987). Thus, benefit levels were rolled back and the growth of federal spending on welfare was scaled back. Some traditionally-federal responsibilities were transferred to state governments and selected programs were eliminated altogether (Romig, 1991).

By the end of the 1980's, a new bi-partisan consensus on welfare was emerging in the center and the traditional gulf between liberals and conservatives on social policy was reconceptualized. This was partly a result of the advent of neo-conservatism and neo-liberalism--pragmatically-oriented political philosophies that shunned traditional party ideology. During President Bush's administration, a group of progressive conservatives, including HUD Secretary Jack Kemp and Education Secretary Lamar Alexander, sought to redefine Republican social policy under the rubric of the New Paradigm group (Galston, 1991). Although tenets of traditional conservatism were present (such as a preference for small government and a resistance to taxes), other new elements of the approach included the view that government should empower citizens, that the federal government has a central role in poverty policy, that bureaucracies should be decentralized, and that many government programs (such as public housing) should be privatized.

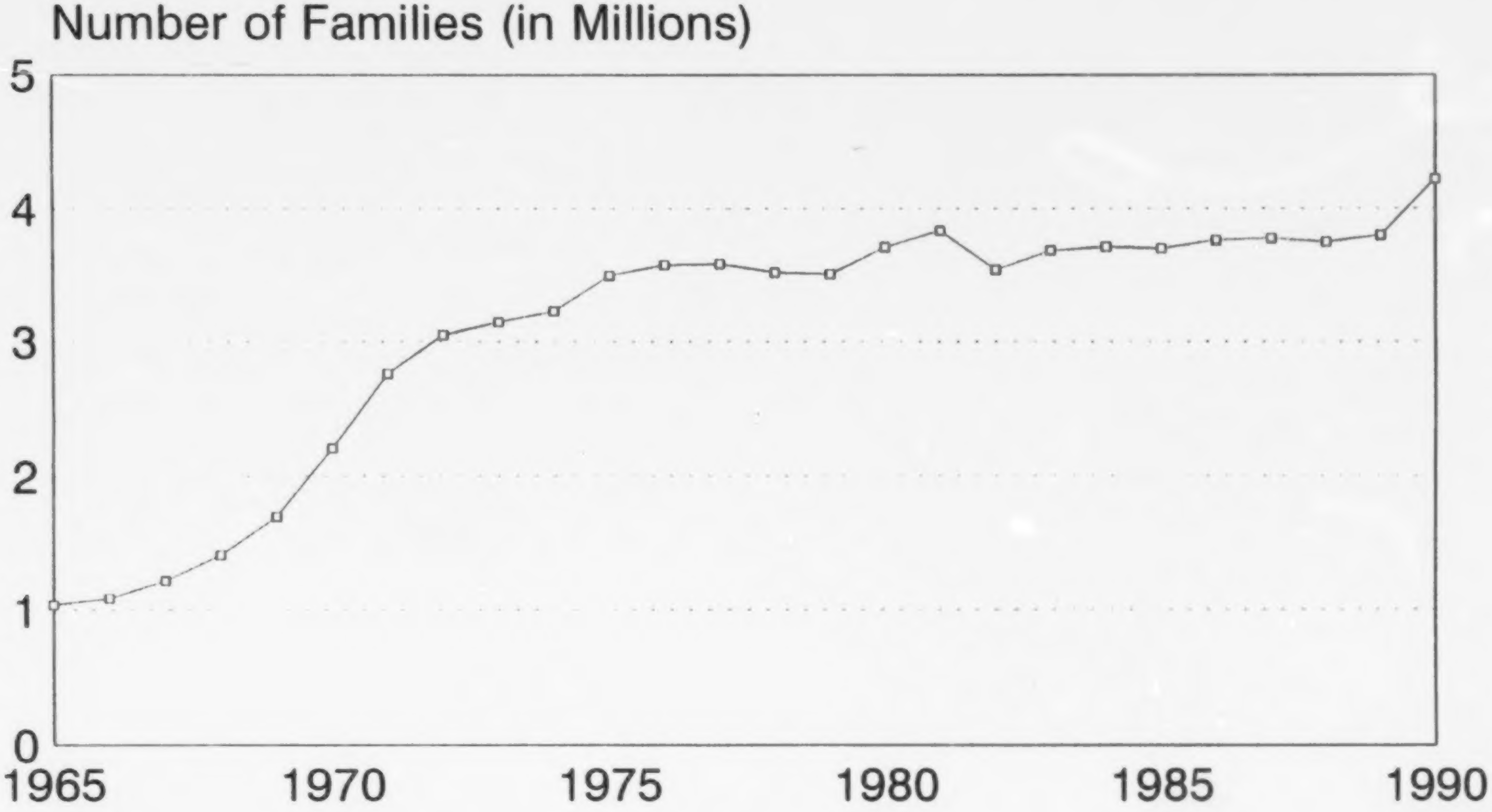
At the same time, a new wing of the Democratic party was emerging which stressed individual responsibility, reciprocity, civic duties and obligations, free market enterprise, social choice, and national service (Marshall, 1992). Organized in the early 80's under the Democratic Leadership Council, of which then Governor Clinton was a founding member, the group sought to reinvigorate the political center and to forge policy not on the ideological orthodoxies of the past, but on a pragmatic pursuit of policies that **work**. The so-called "New Democrat" approach rejects big government in favor of choice, competition, reciprocity and market incentives. A view that became widely popular during the past decade is that "..the kind of governments that developed during the industrial era, with their sluggish, centralized bureaucracies, their preoccupation with rules and regulations and their hierarchical chains of command no longer work very well (Osborne and Gaebler, 1992; pp. 11-12).

The trend of many traditional liberals to move to the center was also strengthened by events in Europe. The rapid dismantling of the formerly socialist nations of the Warsaw Pact lent credence to those who were contending that state socialist ideologies were rapidly becoming extinct. A view of benevolent states acting in the public interest came to be seen as naive and anachronistic in countries from Europe to Latin America (Lusk, 1992). In addition, the "model" welfare states of Britain and Sweden began to reduce benefits, privatize services, and redefine the notion of unconditional social entitlements as a right of citizenship (Barrett, 1993; Marklund, 1992).

Indicative of a new consensus on welfare was a June 1993 speech by Health and Human Services Secretary Donna Shalala. In a significant departure from previous Democratic administrations, she said, "I don't think we should subsidize poor mothers who stay out of the workforce when working class mothers are going into the workforce" (Shalala, 1993).

The changing political context of the past decade made welfare reform in the United States possible. Virtually every president since John Kennedy advocated for a major overhaul of the welfare system and none was successful in altering the incentive structure nor stemming the growth of the client caseload (See Figure 1). But by 1988, a consensus had emerged between the parties on the failures of the welfare state, thereby making the passage of the Family Support Act possible.

Figure 1:
Average Monthly Number of Recipients, Aid to Families with Dependent Children, USA



Sources: Social Security Annual Statistical Supplement, 1991
Statistical Abstract of the United States, 1992

State Experiments in Welfare Reform

Given the new latitude provided under the Family Support Act to conduct large scale experiments in the administration of AFDC programs, many states embarked on initiatives that changed the terms of the contract in family assistance from entitlement to exchange. Wyoming's current welfare reform measure represents the latest initiative in this national trend. State governments were required by federal statute to establish Job Opportunities and Basic Skills (JOBS) programs by October 1990 and all had such programs in place by that time (Clinton and Castle, 1991). JOBS, a limited welfare-to-work program, requires states to provide clients with basic education, job training, job search skills, as well as job development and placement. All non-exempt AFDC recipients are required to participate in employment and training activities when child care services are available. Although the JOBS program does not include funding for large scale job creation through economic development, it has at least had the effect of putting workfare back into the mainstream of welfare policy.

Within this legislative framework, several states have experimented on a large scale with workfare and, in contrast with the pessimism of social work academics who had vigorously asserted that workfare was bound to fail (cf. Abramowitz, 1988; Segal, 1989; Sanger, 1990), many of the experiments showed promising results.

Early reviews of workfare evaluations had shown that a major obstacle to the success of welfare-to-work programs was access to child care (Dickinson, 1986); this obstacle was addressed in the Family Support Act which requires that states guarantee participants with adequate and appropriate child care (Segal, 1989). Programs such as Work Incentive (WIN) had also been criticized as "make work" programs that did not generate the higher paying positions needed for long term success. Although some experiments, such as the California Work Experience Program (CWEP), showed modest improvements in employment and income, the workfare efforts of the 1970's were generally disappointing.

Under the provisions of the Family Support Act, however, state experiments began to succeed more often than fail. In the most comprehensive review of such workfare programs yet published, Gueron and Pauly (1991), noted that, "Almost all of the welfare-to-work programs studied led to earnings gains. This was true for both low and high cost programs and services, and for broad coverage and selective voluntary programs" (p. 26). Gueron and Pauly's work for the Manpower Demonstration Research Corporation (MRDC) involved a five year national review of dozens of welfare-to-work programs. Among their more important results was the finding that improvements in earnings had a lasting impact of at least three years. Programs which had a universal mandatory job search component more consistently increased earnings and employment rates because they reached more people and acted as a deterrent to remaining on welfare. These results did not surprise economic assistance workers and others who work directly with AFDC families. Despite myths to the contrary, AFDC recipients prefer work over welfare and actively seek to be involved in the labor force when the obstacles of child care and health care can be overcome (Kerlin, 1993).

A cost savings to government budgets was also observed. While welfare-to-work programs initially cost more than conventional public assistance programs, these investments were usually "..offset by savings in expenditures and tax increases" (p. 33). The San Diego Saturation Work Initiative Model (SWIM) was particularly effective in this regard. Every dollar invested yielded a three dollar return (Gueron and Pauly, 1991). The MRDC research was corroborated by Moffitt (1991), who found that the total earnings of workfare participants often increased significantly. What is remarkable about the positive findings is that they occurred during a national recession which may well have masked even more profound employment effects.

The Wyoming Context

Wyoming, like the rest of the union, has experienced rapidly growing AFDC caseloads (see Figure 2) and increasing budgetary allocations for public assistance. Public support for welfare programs as traditionally defined is minimal. Wyoming has a strong cultural tradition of self-reliance and rugged western individualism that stands in stark, if not schizophrenic, contrast to the harsh economic realities of the state. Few have done well in the state over recent years and the national recession has been felt even more acutely in Wyoming.

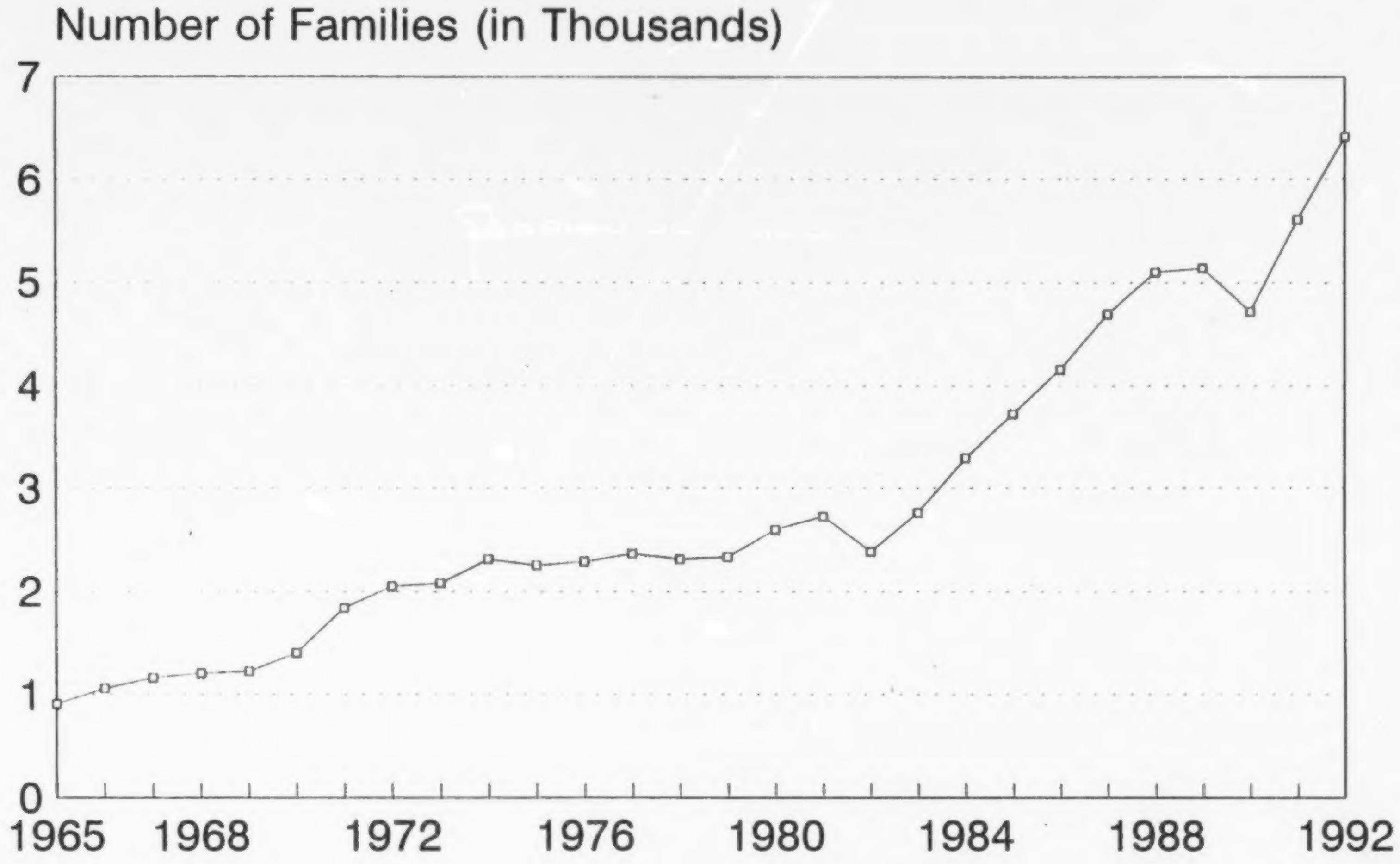
While the state enjoyed a period of strong economic growth during the seventies, the past decade has been one of marked economic decline. Total employment dropped steadily during the period and state per capita income growth fell below national per capita income growth every year during the past ten (Department of Administration & Information, 1992; p. 22). Many of the state's youth have been compelled to migrate out-of-state for employment; overall, the state population fell from 469,557 in 1980 to 453,588 in 1990 (Department of Administration & Information, 1992).

The state's economic situation is most commonly linked to the decline in prices (and thus production of) minerals, petroleum, and natural gas as well as an unstable market for agricultural products. State revenues are tied directly to the well being of these industries. Wyoming draws the largest portion of its revenue from mineral severance taxes as there is no income tax and property and sales taxes are comparatively quite low. Severance tax revenues and total tax revenues have also decreased over the decade. One effect of this protracted period of economic decline is that the poor of Wyoming have had access to a very weak labor market. In addition, without a diverse revenue portfolio, Wyoming state-supported programs face continuing pressure from elected officials to reduce costs and improve efficiencies. Public welfare is no exception.

Wyoming Welfare Reform

In this pressing environment, the Family Support Act has provided an opportunity for the state to experiment with welfare reform. Thus, in December 1992, Governor Sullivan proposed a welfare reform package that was enacted into law by the legislature in early 1993. The Governor's rationale was the limited revenue base to support state programs, erosion of public support for welfare, dependency of recipients, and legislative initiatives to limit benefit levels

Figure 2:
Average Monthly Number of Recipients, Aid to Families with Dependent Children, Wyoming



(Office of the Governor, 1992). The bill requires federal waivers, so the Governor hand-delivered the measure to President Clinton in May 1993.

Key elements of the Wyoming welfare reform package include a trial workfare program. In three pilot counties (Natrona, Campbell, Carbon), all able-bodied AFDC recipients are required to work or perform community service. Recipients can be exempted from this requirement if they are enrolled in an approved education or training activity that involves at least forty hours per week. The Department of Family Services (DFS) collaborates with the Department of Employment (DOE) in providing employment-related services to assist AFDC clients obtain work. To reinforce working clients, the allowable resource limit was raised from $1000 to $2500 and clients are provided with work essentials such as clothing, tools, transportation, and most importantly, child care. DFS and DOE staff are to provide counseling and support to those AFDC recipients entering or designated to enter the work force. In addition, employers are encouraged to provide job coaching to help the recipient entering the workforce or adjusting to a new job. Recipients who cannot find employment after a reasonable period are referred to community service work by the Employment Service.

The education and training option is provided for those who lack the job skills to compete in the labor market. A case manager and the client jointly develop an individualized self-sufficiency plan with the goal of employment and the means to that end are designated. Training and education options go well beyond the minimal requirements of the federally-mandated JOBS program and include: job search and readiness training, remedial education, adult education, vocational education, and higher education. Clients can be trained in one vocational preparation or college degree program only. The legislation limits AFDC and Medicaid benefits to six months after a client successfully completes a vocational, two year, or four year college program. The restriction does not apply to otherwise eligible children.

The high fiscal impact of the training component is to be offset by long term reductions in case rolls. In addition, the Wyoming legislature established the AFDC payment standard at 87.5% of the standard of need (SON) - commonly referred to as a ratable reduction of the SON.

Another component of the Wyoming reform effort is to assist recipients become self-sufficient by strengthening child support enforcement. The Wyoming position is that effective collection of child support is a cornerstone of welfare reform (Office of the Governor, 1992). Early reports on the Clinton Administration's welfare reform proposal also stress collecting support from absent parents. The Administration, noting that national AFDC caseloads in 1993 have reached a total of 5 million families, has asserted that strict enforcement of child support will be key to federal welfare reform (Clinton team, 1993). The plan includes voluntary income withholding when possible supplemented by court-ordered mandatory withholding when it is not. In Wyoming, the district courts may now order able-bodied, unemployed absent parents of children on AFDC who are unable to fulfill a court-ordered child support obligation and who reside within the state to participate in the state's education, employment, and training program for AFDC recipients. Under the JOBS program, or Wyoming Opportunities for Work (WOW), as the JOBS program is known in Wyoming, unemployed absent parents receive the same assistance in job search, work readiness, employment training, and education as AFDC clients. This sends not only the message that the state is serious about enforcing parental responsibility, but also that the state is willing to provide the mechanisms and support for placing both parents in the labor force. Other child support legislation enacted by the welfare reform effort include:

- changing child support guidelines to presumptive child support amounts;
- establishing paternity by voluntary acknowledgement or by court action;
- counting the income of both parents in setting the amount of child support;
- voluntary income withholding for child support payments can be withdrawn only when all arrearages are paid, and;
- limiting conditions for petitioning a stay of an income withholding order.

Because it is important that communities be stakeholders in the success of the poor, the Wyoming reform establishes task forces in each of the three workfare pilot counties to coordinate activities leading to the employment of AFDC recipients. Appointed by mayors and county commissioners, each task force includes representatives from the private sector and delegates from four state departments: Family Services, Education, Employment, and Health. Such task forces sensitize community leaders to AFDC clients' needs and abilities and remove roadblocks to self-sufficiency. Local leaders are in a better position to know their communities and promote economic development.

Recognizing that the public assistance system itself is in need of reform, the Wyoming plan has undertaken to significantly reduce paperwork, bureaucratic roadblocks, and AFDC monthly reporting requirements. Osborne and Gaebler (1992), have stressed results-oriented rather than process-oriented government. While organizations in the private sector survive by performance and efficiency measures, it is often the reverse with public agencies. The traditional presumption of process-oriented bureaucratic models of government has been that greater caseloads require additional funding; poorer schools need more resources, and dangerous neighborhoods lack sufficient police officers. More public agencies are turning this logic upside down by rewarding success and the Wyoming reform reflects this trend.

In sum, Wyoming welfare reform stresses: independence through employment; investment in education, training, and job skills for work; strengthening families through child support; extending the penalty for fraud; and increasing the resource limit for working AFDC recipients.

Looking Forward

As the least densely populated and most rural state in America, Wyoming faces special challenges in adapting welfare reform to its unique, frontier context. Welfare-to-work programs are designed with the assumption of a stable and diverse labor market, a level or growing economy, sufficient density of population and industry to support a varied work force, and an AFDC caseload that provides an economy of scale for implementing major program changes and reform (Gueron and Pauly, 1991; Whitener, 1991; Harper and Greenlee, 1991). Some of these conditions are not present in Wyoming's rural counties.

Although about 295 thousand of Wyoming's 454 thousand residents live in "urban" areas of 2,500 or more (65%), most of these reside in one of four metropolitan areas: Casper, Cheyenne, Laramie, and Jackson. Only one Wyoming "city" (Cheyenne) exceeds a population of 50,000 and it does so by only eight people! Fully 35% of Wyomingites live in rural areas--many in isolated frontier communities with populations of less than 100 residents.

Whitener (1991) has observed that rural areas must contend with three complicating factors in making welfare reform successful: 1) limited employment opportunities, 2) lower than average educational characteristics of rural populations, and 3) the inadequacy of the local social service delivery system. He notes that rural environments are characterized by high unemployment, limited job opportunities, and isolated rural conditions which may serve as a disincentive for business growth. He also observes that rural Americans have lower educational and vocational achievement, higher rates of illiteracy, and greater proportions of the particularly disadvantaged. Finally, he comments that economic assistance and social services delivery systems and infrastructure are often minimal in isolated rural settings.

All of these factors which complicate welfare reform in rural areas will ultimately have to be confronted in Wyoming if the state's plan is to be successful over the long term. Yet the situation is not as grim as might be anticipated. With respect to education and training opportunities, Wyoming is well ahead of other rural regions, such as Appalachia, where welfare reform has been hampered by the inaccessibility of schools and colleges (Harper and Greenlee, 1991). Wyoming has a major university with campuses in two cities as well as seven community colleges which are evenly distributed geographically. Educational programs are broadcast statewide via a state-owned video teleconferencing network. The state is well positioned to reach its rural residents and provide job training. The greater challenge is not in outreach services, but in the more difficult task of promoting economic development in a state that has relied on agriculture and extractive industries since its founding.

Conclusion

Child support enforcement, education, training, and welfare-to-work programs are an important first step in helping the poor achieve economic self-sufficiency, but such programs alone cannot be expected to address the more far reaching economic issues which underlie poverty. Workfare and the attendant components of welfare reform are useful in providing skills, incentives, and supports for families as they strive for economic security, but welfare reform cannot change the context of the labor market. Poor families in Wyoming and elsewhere will become fuller participants in the economy only when the labor market can absorb, integrate, and fully employ the nation's disadvantaged.

REFERENCES

Abramowitz, M. (1988). Why welfare reform is a sham. The Nation, September 26, p. 239.

Barrett, G. (1993, February 10). Welfare state under the knife. The Age, (Melbourne, Australia), p. 8.

Bauer, P.T. (1981). Equality, the third world, and economic delusion. Cambridge: Harvard University Press.

Clinton, Gov. B. and Castle, Gov. M. (1991). The states and welfare reform. Intergovernmental Perspective, Spring, pp. 15-17.

Clinton team begins work on welfare reform proposal. (1993, June 2). Casper Star Tribune, p. 1.

Department of Administration and Information (1992). Wyoming Data Handbook 1991. Cheyenne, WY: Author.

Dickinson, N.S. (1986). Which welfare work strategies work? Social Work, 31 (4), pp. 266-272.

DiNitto, D. (1993). Should we expect to change clients' behavior in exchange for aid? No! In: H. Karger and J. Midgley (Eds.) Controversial Issues in Social Policy. New York: Allyn and Bacon.

Galston, W.A. (1991). Paradigm lost. The New Democrat, 3 (4), pp. 22-27.

Gueron, J.M. and Pauly, E. (1991). From welfare to work. New York: Russell Sage Foundation.

Harper, K.V. and Greenlee, R.W. (1991). Workfare programs in rural America: Joblessness in Ohio's Appalachian counties. Journal of Sociology and Social Welfare, 18 (1), pp. 71-90.

Karger, H.J. and Stoesz, D. (1990). American social welfare policy: A structural approach. New York: Longman.

Kerlin, A.E. (1993). From welfare to work: Does it make sense? Journal of Sociology and Social Welfare, 20 (1), pp. 71-85.

Lusk, M.W. (1992). Social development and the state in Latin America: A new approach. Social Development Issues, 14 (1), pp.10-21.

Lusk, M.W. (1993). Should we expect to change clients' behavior in exchange for aid? Yes! In: H. Karger and J. Midgley (Eds.) Controversial issues in social policy. New York: Allyn and Bacon.

Marklund, S. (1992). The decomposition of social policy in Sweden. Scandinavian Journal of Social Welfare, 1 (1), 2-11.

Marshall, T.H. (1981). The right to welfare. New York: The Free Press.

Marshall, W. (1992). The politics of reciprocity. The New Democrat, 4 (3), pp. 4-7.

Mead, L. (1986). Beyond entitlement: The social obligations of citizenship. New York: Free Press.

Miller, D.C. (1989). Poor women and work programs: Back to the future. Affilia, 4 (1), pp. 9-22.

Moffitt, R. (1991). Welfare reform in the 1990's: The research view. Intergovernmental Perspective, Spring, pp. 31-33.

Murray, C. (1984). Losing ground: American social policy 1950-1980. New York: Basic Books.

Nichols-Casebolt, A.M. and McClure, J. (1989). Social work support for welfare reform: The latest surrender in the War on Poverty. Social Work, 34 (1), pp. 77-80.

Office of the Governor (1992). Welfare reform: New opportunities and new responsibilities. Cheyenne, WY: Author.

Osborne, D. and Gaebler, T. (1992). Reinventing government: How the entrepreneurial spirit is transforming the public sector. New York: Addison-Wesley.

Rector, R. (1992). The paradox of poverty: How we spent $3.5 trillion without changing the poverty rate. Washington, D.C.: The Heritage Foundation.

Romig, C.L. (1991). Welfare reform: How well is it working? Intergovernmental Perspective, Spring, pp. 20-23.

Sanger, M.B. (1990). The inherent contradiction of welfare reform. Policy Studies Journal, 18 (3), pp. 663-680.

Segal, E.A. (1989). Welfare reform: Help for poor women and children? Affilia, 4 (3), pp. 43-50.

Shalala sets out views on welfare mothers. (1993, June 4) Casper Star Tribune, p. 1.

Whitener, L.A. (1991). The JOBS program and rural areas. Rural Development Perspectives, 7 (2), pp. 21-26.

Focus Group Process and Results: What Clients Have to Say about Welfare Reform

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In 1987 Delaware developed its first multi-year welfare reform plan. In 1992, at the end of that five year plan, the Division and its Social Services Advisory Council (community advocates and leaders) realized we could not move forward with a new plan without a review of the current social and economic climate. They found conditions were very different from what they had been just five years earlier.

Out of that realization, and in concert with the agency VISION to empower staff and clients, it was determined a major aspect of developing our new welfare reform plan would consist of conducting a series of focus groups. The intent of the focus groups was to get input from all the players in the welfare system: clients, staff, community advocates and leaders, and providers.

The Division of Social Services (DSS), its Social Services Advisory Council and the Division of Child Support Enforcement (DCSE) came together to develop a plan. Participants were selected via recommendations from staff and providers. Neutral sites were selected throughout the state to reinforce the clients feeling of comfort.

A sub-committee of the three groups (DSS, DCSE, and the Advisory Council), worked together to develop a set of questions. The questions had to be open-ended to foster greater input and their number had to be kept to a minimum.

A consultant was hired to train 16 volunteers in the focus group process. These volunteers included members of the Social Services Advisory Council as well as DSS and DSCE staff. The consultant reviewed the questions and the final format was set. A total of 12 focus groups were developed. The optimum size of each group was 8 to 10; large enough to obtain a good cross sectional representation but not so large as to become unwieldy. The groups were divided into groups of

- staff from DSS
- staff from DCSE
- clients
- community advocates
- community leaders
- child support professionals and
- providers, both contracted and medical providers.

Of the twelve groups, five were client oriented and one of the five was directed specifically to teen age clients. The five client groups were video taped by an independent contractor. Eight hours of raw footage was edited down to the 1/2 hour tape we will view this afternoon.

Each focus group was conducted by a three person team; a facilitator, a recorder and an observer. The facilitator posed the questions exactly as they were written so as not to inadvertently change the intent of the question. He also kept the participants focused and encouraged communication without being judgmental.

The recorder recorded the responses verbatim. At the conclusion of each question the recorder read back the responses to assure the information recorded was not only what the participant said but also what was meant.

The observer acted as an assistant to the facilitator. He provided feedback to the facilitator that may have missed during the information exchange, i.e. a participant becoming agitated or aggressive or withdrawn.

Client feedback was focused into three primary areas and closely mirrored feedback from staff and providers. Topics were transitional benefits, parenting, and dreams and goals. In the area of transitional benefits they all agreed benefits should not be cut so quickly. Clients wanted additional supports after the loss of benefits in child care, transportation, medical assistance and housing. It was felt that these supports were paramount in aiding the clients in attaining their goal of self-sufficiency and to reduce the chances of returning to the public assistance rolls.

With respect to parenting, education of the children and the parents was of prime concern. Clients also voiced the opinion that cash benefits were too low to adequately care for the needs of a child. Dreams and goals included the desire to improve or to complete their education; the need for more First Step (Job Opportunities and Basic Skills Training Programs (JOBS)) programs (especially programs directed toward the significant other of the AFDC participant) and jobs that pay more than minimum wage.

The written and visual feedback was processed during the six week period immediately following the conclusion of the focus groups. That information was used to develop our VISION statement and a new welfare reform plan was drafted with three main themes:

1. *Rewarding work* with programs like Fill the Gap;
2. *Family responsibility* which would include cooperation with the Division of Child Support Enforcement and entering into a social contract as part of the Employment and Training (JOBS) plan; and

3. *Family support*:

- expanding Employment and Training programs
- increasing Child Care program subsidies and slots
- providing housing supplements.

A Welfare Reform Conference was held in October, 1992 to which client participants, staff and the public were invited. The edited version of the video tape was viewed not only to share the information gathered but also to assure the clients that they were presented in a respectful light. Their ideas, goals and dreams were invaluable to the welfare reform process.

Washington State Refugee Self-Sufficiency Initiative

Thuy Vu, Ph.D., Washington Division of Refugee Assistance

The Refugee Act of 1980 defines refugees as individuals who are "unable or unwilling to return to their country of origin because of persecution or well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." In 1992 over 130,000 refugees were admitted to the United States. Approximately 46 percent of this total came from the former Soviet Union and Eastern Europe, 39 percent from Southeast Asia, six percent from the Near East and South Asia, four percent from Africa, and three percent from Latin America and the Caribbean.

In total numbers, Southeast Asians remain the largest refugee group admitted since the end of the Vietnam war in 1975, with about 1,086,000 total arrivals. Ten states have Southeast Asian refugee populations of 20,000 or more and account for about 73 percent of the total Southeast Asian refugee population in the U.S. The states of California, Texas and Washington continue to hold the top three positions. In addition to Southeast Asians, the U.S. also admitted during the 17-year period from 1975 to 1992, 321,000 former Soviet refugees, 40,000 Rumanians, 37,000 Iranians, 38,000 Poles, 30,000 Afghans, 31,000 Ethiopians, and 10,000 Iraqis.

The State of Washington is home to over 60,000 refugees, most of them Southeast Asians. In recent years however, the balance has shifted in favor of refugees coming from the former Soviet Union. In fiscal year 1992, out of 5,300 refugees newly resettled in Washington state, 46 percent were from the former Soviet Union block and 40 percent from Vietnam.

From an economic standpoint, most refugees experience serious barriers to self-sufficiency immediately after their entry in the U.S. This is caused primarily by their lack of preparation prior to their departure for the U.S., their limited English proficiency and lack of readily marketable skills. The emotional trauma that the refugees have experienced in the relocation process also adds to their inability to compete successfully in the job market. In addition, unlike legal immigrants, refugees are not required to find local sponsors who are willing to provide the necessary financial support after their arrival in the U.S. Consequently, during the first few months immediately following their entry, most refugee households have to rely on public assistance as their primary source of income; therefore, their welfare utilization rate tends to be higher than for the general population.

A survey of Southeast Asian refugees conducted by the Office of Refugee Resettlement in 1992 indicated that only 37 percent of those aged 16 and over participated in the labor force, as compared to 66 percent for the U.S. population as a whole. Of those in the labor force, about 84 percent were actually able to find jobs, as compared with 93 percent for the U.S. population.

English proficiency was found to have a direct impact on refugee labor participation, unemployment rates, and earnings. Refugees who spoke no English had a labor participation rate of eight percent and an unemployment rate of 31 percent; for refugees who claimed English fluency, the labor force participation rate was 48 percent and the unemployment rate was 17.2 percent. Lack of transferable skills and post traumatic depression also contribute to the high unemployment rate of refugees during their initial period of resettlement in the U.S.

For those refugee families who are unable to become immediately self-sufficient, public assistance is being offered as their primary source of subsistence. Access to the public assistance system by refugees is expected to be short term and emergent by nature. Unfortunately, for a number of refugees, the duration on assistance may last for an extended period of time. The risk of their becoming welfare dependent has become a sensitive issue among policy makers, both at the state and national levels.

As a result, the issue of welfare utilization by refugees and potential welfare dependency among refugees has always been a key concern to those responsible for domestic refugee resettlement. Many efforts are being initiated at the state and federal levels to help refugees speed up their process of economic self-sufficiency.

One of the efforts initiated in Washington state has been the Refugee Self-Sufficiency Initiative funded under the federal Key States Initiative (KSI) grant.

Section I: Project Description

The Key States Initiative Project was implemented in 1988 through a cooperative agreement between the State of Washington and the federal Department of Health and Human Services/Office of Refugee Resettlement. Currently in Year 6, the Washington Refugee Economic Self-Sufficiency Initiative is a service model designed to promote early economic self-sufficiency for refugees. The project is administered by the Division of Refugee Assistance (DORA) within the Washington Department of Social and Health Services, in close cooperation with local community based employment and training networks, refugee resettlement Voluntary Agencies (Volags), and community colleges and vocational schools.

The initiative's primary goal is to reduce welfare reliance of refugees through the establishment of a self-directing program. Refugee welfare recipients, as part of their self-sufficiency planning process, are expected to participate in one of the two following plans, called "Tracks:"

Track I is offered to those refugees who can become self-sufficient over time but at present must rely on full public assistance because of severe and multiple barriers to economic self-sufficiency.

Track I participants receive self-sufficiency case management services, which focus on barrier removal activities such as language training, job and career preparation. Case management services start with a comprehensive assessment of the individual's skill(s) and employment barriers. Comprehensive language and skill assessment are carried out by English as Second

Language (ESL) teachers, employment counselors and social workers. From this process, personal self-sufficiency plans for the clients are developed which focus on removing those barriers that prevent the refugee from participating successfully in the job market. Clients are then referred to services as listed in the self-sufficiency plans. As part of the self-sufficiency case management activities, job leads are offered to the refugees at regular intervals. The employment case managers are responsible for developing job leads and offering them to the refugees they assist.

The clients and their case managers are asked to jointly develop and sign the self-sufficiency plan. The desired outcome of Track I is the successful placement of the client in unsubsidized employment. Follow-up is provided for up to one year after entry into the job market to ensure that medical, child care, and employment related issues affecting long term employment status and career goals are addressed.

A major aspect of the economic self-sufficiency case management is the bilingual/bicultural approach provided. Over 80 percent of the case managers working with the project's population are either bilingual, bicultural or both. Approximately 10 language groups are covered: Russian, Vietnamese, Cambodian, Laotian, Chinese, Hmong, Eritrean, Amharic, and other Eastern European languages.

Another key component of the case management service is the involvement of community organizations, especially local Refugee Resettlement Centers and most importantly, Voluntary Agencies (Volags) responsible for bringing refugees to Washington. This component is important primarily because these agencies are usually the first contact a refugee makes. Many of these agencies are often able to demonstrate to newly arrived refugees that immediate economic self sufficiency through employment is more fruitful in the long run than entering cash assistance programs - therefore, they "divert" the clients from ever receiving cash assistance. Those clients who succeeded to stay out of financial assistance are being referred as "grant diversion" cases. By diverting new arrivals from public assistance or working intensively with clients who have accessed state cash assistance for only a short period of time, the chances of keeping them off assistance once they become employed is greater, since they have not become dependent on welfare.

In 1992, over 3,000 Track I refugees received case management services and over 1,500 were enrolled, as part of their self-sufficiency plans, in short term language and skill training classes.

Track II:

To those refugees who desire to move out of public assistance but are reluctant to do so because of fear of losing benefits and/or not being able to hold on to a job, an alternative plan is offered in the form of the Track II program. This program is intended to bridge the financial gap between welfare and entry level employment. It is primarily designed to assist the working poor, helping them to cover, on a limited time basis, some of the costs that result from taking low entry level paying jobs. It is well known that the transition from welfare to employment initially drains the client's resources due to the costs associated with transportation to and from work, child care, medical care, work clothing, training, etc. Therefore, the objective of Track II is to fill the gap between reduction in welfare benefits and increase in income due to earnings.

The program provides support to newly employed refugees through reimbursement of the following out-of-pocket expenses: transportation, tools, tuition, training supplies, medical insurance premiums or co-payments, and in single parent and dual employment households where both spouses are working, child care expenses. Reimbursement for post-employment training expenses is allowed in order to assist the employed client to take advantage of training opportunities in order to enhance employment stability and to avoid reverting to public assistance.

Several eligibility features are instituted to secure the cost-effectiveness of the Track II program, namely:

- To qualify for Track II support services, the welfare recipients must first reduce or terminate their assistance grant.
- This is a reimbursement program, i.e. clients must incur the expenses before they can file any claims.
- Only refugee families with income below the state standard for public assistance are eligible to participate.
- During any given month, the amount of reimbursement cannot exceed 50 percent of the welfare reduction as documented in the client's file.
- The Track II employment support is time-limited, i.e. available for up to twelve months, depending upon the type of assistance the refugee had been receiving.

During the 12-month period of **KSI Year 5,** from October 1, 1991 to September 30, 1992, **554** refugees participated in Track II activities as a result of employment. Three hundred seven **(307)** new clients enrolled and participated in the program. Eighty-two percent **(82%)** of the clients were receiving public assistance prior to their enrollment in the program. The remaining **18%** were "grant diversion" cases, i.e. new arrivals who opted to participate in the Track II program instead of going on public welfare.

Perhaps the most significant of all outcomes was the fact that **over half** **(57%)** of the 554 participants voluntarily enrolled in Track II. These **315** individuals had formerly been recipients of AFDC or FIP (Family Independence Program assistance), and were therefore not mandated by law to participate in any type of employment, training, or related activity.

During the first three quarters of **KSI Year 6** (October 1992- June 1993), **443** participants received Track II services. Two hundred eighty-four **(284)** were new enrollees. Approximately **84%** were self-sufficient and received no welfare grant; i.e., they never accessed cash assistance or were able to terminate their cash assistance as a result of employment. The remaining **16%** received partial cash assistance due to part-time employment, low wages, or larger families.

Eighty-three percent of all Track II participants **(367 persons)** came from the public assistance system, including **65% (288 persons)** from the AFDC and FIP programs **(15%** of whom were single parents), and **18% (79 persons)** from the Refugee Cash Assistance (RCA) program.

Over **33%** of all participants had been in the country less than six months at the time of participation, **24%** had been in the country from six to twelve months, **20%** had been in the country one to two years, **9%** from two to three years, and **14%** over three years. The number of participants who have been in the country less than one year and more than three years has increased since Year 5.

Over **65%** were volunteers from the AFDC programs so far this year. This is a significantly high percentage since Washington state continues to allow AFDC recipients to volunteer for programs and does not mandate participation.

Over the years, the Track II program has become well known throughout the state as a viable alternative to cash assistance. Its success has increased the project's attractiveness even during a fiscal year when budget constraints have forced us to cease outreach activities and curtail program endeavors to fit the reduced budget.

The popularity of this program increases each year primarily through word of mouth by Track II participants as well as intensive counseling by Volags, social workers and employment counselors. Clients who have been in the country more than one year are now eager to move out of public assistance. This is a trend that we want to encourage, especially in light of reduced funding in the refugee cash assistance grant.

Voluntary agencies continue to participate in the program and are gradually increasing the number of families they successfully divert from cash assistance. In Year 5, eight contracts were entered into with Voluntary Agencies; at the end of the year, a total of **203** newly arrived refugees had been served. Of these, 117 persons **(58%)** were "grant diversion" clients.

During the first three quarters of Year 6, the Volags served 124 participants: Jewish Family Service assisted 41 Track II participants, the International Rescue Committee assisted 38, World Relief 18, United States Catholic Conference 18 in Spokane, Lutheran Refugee Program 5 and Church World Service served 4.

These statistics reflect a new trend in Washington state as a result of the Self-Sufficiency program. Clients on AFDC who are in fear of losing the security of monthly welfare payments are being encouraged to take advantage of a program that helps them "get on their feet" in a difficult transition period. All too often, transportation costs, day care expenses, and lack of medical coverage or insurance are such overwhelming burdens that they become the main reasons for clients to shy away from employment, or to immediately return to the shelter of welfare once they find that minimum wage-paying jobs do not adequately cover their living expenses and the expenses associated with employment.

A survey of project staff and employment counselors involved in the self-sufficiency program has confirmed that time-limited reimbursement of work-related expenses combined with intensive employment barrier removal services have been direct factors in assisting refugees retain employment and achieve self-sufficiency.

Section II: Program Impact

Recently, Deloitte & Touche, a national consulting firm, was selected and funded by the federal Department of Health and Human Services/Office of Refugee Resettlement (DHHS/ORR) to evaluate Washington state's program. This was the second of two studies of the program and involved on-going assessments of program operations with analyses of program impact on participants. Final results of the first study were published in November 1990; results of the second study in draft form were recently received, and will be formally published shortly.

Evaluation Methodology:

In order to evaluate the program impacts, Deloitte & Touche:

1) researched and analyzed increases in self-sufficiency and decreases in welfare utilization by participants due to employment;

2) identified characteristics of refugees who became employed and were able to move off welfare or reduce their reliance on welfare; and

3) assessed the cost-benefits of the initiative by comparing grant reductions and terminations due to employment with programmatic and administrative costs, including reimbursements to participants.

In the most recent study, 936 individual refugees who received Track II services (representing 793 families) were studied, which represented 14% of the total 6,700 refugees on public assistance who entered employment during this time frame. In addition, field research was conducted, consisting of interviews with social workers managing refugee cases, and reviews of 111 randomly selected Track II case files.

Over 100 case files belonging to participants who had exited the program were also reviewed to provide the evaluators with a greater depth of understanding of program operations, as well as verification of Track II and welfare participation. In order to estimate possible gains and benefits that involvement in Track II may have afforded to its participants, the evaluators compared the Track II population's results with those of a comparison group of refugees who had welfare and earnings experience during the same study frame. As reported in the initial study and further discussed in the more recent study, acquisition of employment alone does not guarantee self-sufficiency.

"Self-sufficiency due to employment is a consequence of higher wages, longer job duration and full-time employment."[1] Therefore, instead of relying on employment rates and number of participants with grant reductions alone to help assess the extent to which participants were successfully employed and economically self-sufficient, Deloitte & Touche examined relative earnings levels, earnings growth over time, and sustained employment.

The evaluators also performed an in-depth analysis of program participants' demographic characteristics, employment history, welfare payment history and status, and program benefits in order to determine if there were specific clients who benefitted the most from this type of initiative, and if there were any patterns or implications for further study and/or revision of the project design.

Findings:

- During the 27 month study period evaluated, approximately 6,700 refugees from public assistance households entered employment, with over 14% accessing Track II benefits.
- Track II participants represented a wide range of family size and composition, ethnicity, time spent in the United States, and education experience
- Track II attracted more families (50% of the participants) than Track I, which served a population of 31% single individuals and 35% families of three to five individuals. The typical Track II participant is a married head of household with one or more children (average of 3.15 individuals). Single individuals only represented 28% of the total study population.
- 18% of the households had more than one wage earner.

In order to determine the cost benefit of this program, the evaluators studied participant welfare savings due to employment (i.e., how much of a reduction occurred in welfare payments to clients as a consequence of employment), increased earnings during participation in the project, and the difference between the program's incremental welfare savings and programmatic costs incurred in administering the project and reimbursing clients. Study results showed that:

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[1] "Evaluation of the Track II Program, October 1989 to December 1991, Office of Refugee Resettlement, Deloitte & Touche, February 1992, and "Evaluation of the Key States Initiative, State of Washington, First Year Report," February 1990.

- the average wage of participants was at least 50% higher than minimum wage;
- the majority of participants (80%) entered full-time employment; approximately 80% of Track II participants remained employed one and two years after program enrollment, while non-Track II refugee employment dropped to 60% during the same time frame; of the 1,500 refugees who have participated in the Track II program since October 1988, only **8.6%** have reverted to full cash assistance, and **4.4%** to partial cash assistance.
- Track II participants outperformed non-Track II refugees in terms of earnings levels and job duration. On the average, family income of Track II participants was approximately 23% higher than non Track II participants after one year of employment, and 21% higher after two years of employment. In dollar amount par year, Track II refugees earned almost $2.5 million more than their non-Track II counterparts.
- Track II participants had a higher rate of earnings growth over the study period than their counterparts (the non-Track II comparison group). After one year, the increase averaged 15%, and after two years the total increase was 25%.[2]
- When the amount of welfare savings resulting from a reduction in welfare payments as a consequence of entered employment were analyzed, the research found that Track II participants saved at a rate of 55% higher than non-Track II participants.
- **For every dollar spent, the program resulted in a return of the original expenditure plus an additional $3.92.**

Evaluators also reported that the program is viewed by refugee workers and participants as very successful - Track II provides a positive, tangible incentive (i.e., expense reimbursement) to stay employed and delivers this service on a fast turnaround once the participant is enrolled. The study indicated that good coordination among various organizations and programs has helped Track II become identified as a positive program rather than another rule-driven requirement.

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[2] "Evaluation of the Key States Initiative, State of Washington First Year Report," Deloitte & Touche, February 1990, and "Evaluation of the Key States Initiative, State of Washington," Deloitte & Touche, February 1992.

The Deloitte & Touche survey (as reported in their February 1992 draft report) revealed that many clients accepted employment solely due to the influence of Track II benefits.

Conclusion:

Over the past 5 and ½ years, through outside evaluations and in-house studies, the Key States Initiative Project has been found to have had a major impact on resettlement activities across the state of Washington. Track II has helped clients by easing the transition from welfare dependency to self-sufficiency at a time when wages are insufficient to make them fully self-supporting. Problem areas such as cultural barriers to work, low literacy levels, and most importantly, refugees' concerns about losing welfare benefits and medical care can be dealt with in special programs offered through the KSI. Many clients, who would otherwise be reluctant to leave the "security" of the "safety net," were willing take the necessary step to transition out of the welfare system.

Another important point to bring out is the fact that many clients are counseled and provided assistance to obtain employment and are successful even though they do not actually receive Track II support services. This occurs for a variety of reasons: some clients simply do not follow through; some clients do not want to complete the paperwork; and in other instances, the social worker and employment counselor are able to find other resources to cover the costs associated with going to work.

This concept of working with clients by utilizing intensive case management which often times is shared between Volags, social workers and community providers begins from a client's initial intake and orientation to the welfare system. The encouragement given to clients to leave welfare and seek self-sufficiency through employment by providing ongoing personalized assistance even after they have entered the job market is innovative. It has also proven to be a motivating factor for clients when they are heavily encouraged to seek employment and provided with resources to help them retain their jobs during their initial struggle in the transition from welfare to work.

Acknowledgements: I am grateful to Mrs. Anne Hankins and Ms. Teresa Martinez for their valuable contributions to this paper.

The Maryland Model

(Perspectives, Price, Partnerships, Problems, and Policy)

A Presentation
to

The National Association for
Welfare Research and Statistics

by

Richard E. Larson
Maryland Department of
Human Resources
Income Maintenance Administration

AUGUST 9, 1993

"...if you don't understand
the perspective, you can't
understand the price..."

Arthur Miller
The Price

NAWRS2

The Price

The price of the Maryland Forecasting Model is very much dependent on your perspective

$600,000 - Total Contract Cost for 14 months

OR

$300,000 - Total Federal Funds brought in by the contract

OR

$300,000 - Total cash/in-kind, including indirect costs contributed by the University

OR

$ 0.00 - State funds in DHR's appropriation

NAWR83

Usual Funding

DHR/Federal

State Funds (in Budget) $1.00 → $1.00 Federal Funds

Totals	$1.00	$1.00

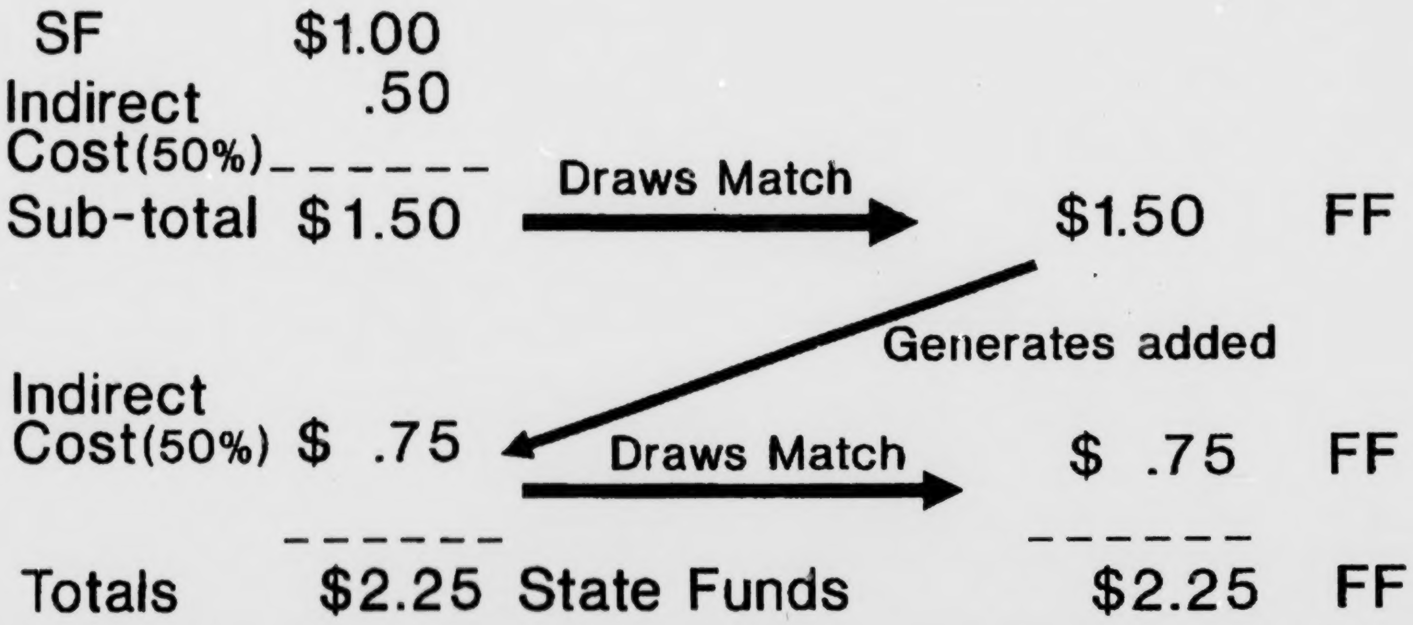
Total Project Cost = $2.00

$1.00 Generates $1.00

NAWRS4

Our Funding

University Partner/Federal



SF	$1.00			
Indirect Cost(50%)	.50			

Sub-total	$1.50	Draws Match →	$1.50	FF
		Generates added		
Indirect Cost(50%)	$ .75	Draws Match →	$ .75	FF
	------		------	
Totals	$2.25 State Funds		$2.25	FF

Total Contract Cost - $4.50

New Federal Funds - $2.25

Contributed Indirect Costs - $1.25

Original General Funds - $1.00

NAVRS6

Source of the $1.00

"All State Money is Green"

The issue still remains:
Where does the original $1.00
come from????

Can be State Funds in Your Agency

BUT

Can also be State Funds Contributed by the University

To The Federal Government if there is a contract between you and the University and the activity is justifiably related to your program "All State Money is Green" and therefore Matchable. This is:

"Fungibility"

The next step is how to persuade the University to give you that $1.00.

Creating Partnerships

Creating, Caring, Nurturing

1. Clear Mutual Self-Interest
   - What Does Agency Get?
   - What Does University Get?
2. What Incentives Can Be Brought to the Table?
   - Monetary
   - Non-Monetary
3. Use #1 and #2 to Market the Partnership within both organizations
   - The need to explain what you are doing
   - Low risk/ low cost can help
4. Start Small
   - Our initial contract was for a short project to do data analysis on an initial survey
   - Contract for Forecasting was our third

Creating Partnerships

Creating, Caring, Nurturing

5. There is a need for Patience

   - Essentially different cultures have to learn to understand, trust, and respect one another

   - Gradualism and Incrementalism are key. Build on project after project.

   - You should also have the sense to walk away from a relationship where mutual interest gets lost

6. There will be continual negotiations

   - Within Agency and University
   - Between Agency and University
     - Source of Matching Funds
     - Range of products
     - Adding your own Money
     - How much indirect costs to give

NAWRS8

Creating Partnerships

Creating, Caring, Nurturing

7. Time and Timing are Important since the two organizations may run on Different Clocks.

   - For Production of Material
   - For the Evaluation of Results
     - Government bureaucracies evaluate to publish
     - Academic bureaucracies publish to evaluate

8. The need for Continuity

   - Learning curves are high
   - Recruiting and retaining quality
   - Institutional credibility needs

9. The need for balance with other Partnerships - The need for clarity as to why you are going elsewhere

NAWR89

Some Products

Maryland Welfare Policy Institute

1. Caseload Forecasting Models
2. AFDC Standard of Need Re-evaluation
3. Study of all Means-Tested Programs in Maryland
4. Study of Other Program Participation
5. AFDC Characteristics Study
6. Focus Groups for AFDC Reform Efforts
7. Organizational Development - Managing the Culture of Change in an Era of Welfare Reform
8. Logistical Support for the Governor's Commission

Some Potential Pitfalls

A. Academic Side
  - Learning Curve
  - Pace/Deadlines
  - Quest for Perfection
  - Pure vs. Applied Research
  - Risk factors - Particularly Political Ones

B. Government Side:
  - Pace / Impatience
  - Needed It Yesterday Syndrome
  - Ambivalence
    - In Awe
    - Intimidated

NAWR811

Some Policy Uses

Commission Issues

General Finding:

"Members of the at-risk population act rationally and select alternatives that bring them the greatest benefit."

Lead to consideration of relative benefits of working and receiving welfare at various wage levels.

Concluded that going on/staying on welfare was at times a perfectly rational decision.

Presently considering ways to make work pay better than welfare not by increasing earned income disregards but by stringent job search/job acceptance conditions of eligibility with wage supplementation to bring Earnings + EITC + Food Stamps up to a minimum level to be determined

NAWRS12

Some Policy Uses

Commission Issues

Specific Uses:

1. Demonstrated that increasing grant levels will increase caseload

2. Demonstrated that adopting certain Fill-The-Gap budgeting strategies in AFDC would result in unacceptably high additional costs

3. Projecting the effect on caseload growth of certain AFDC-UP policy changes being considered including those concerning:

   - 100 hour rule
   - quarters of coverage
   - 30 day waiting period

NAWR813

Federal Initiatives and State Response

Moderated by Wilbur A. Weder
U.S. Department of Health and Human Services
Administration for Children and Families

Program Integration and Uniformity across Programs **-** Karen Green, Division Director, Office of Performance, Measurement, and Evaluation, Planning and Policy Development, U.S. Department of Labor [Oral presentation only]

Electronic Data Transfers: Do We Know What Our Computers Are Doing for Us? **-** Wilbur A. Weder, Chief, JOBS Information Measurement Branch, Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services

State Response **-** Joseph F. Cuccia, Bureau Chief, Statistical Services, Administration Division, California Department of Social Services [Oral presentation only]

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Electronic Data Transfers: Do We Know What Our Computers Are Doing for Us?

Wilbur A. Weder, Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services[1]

Electronic data transfers are very common today. You may not have thought about it, but they are a part of our everyday lives. In fact, the more common ones such as the automatic deposit of your paycheck in your bank account is taken for granted. Unless, of course, something happens to the computer system that prevents the automatic deposit of your paycheck. Then we become painfully aware that automated systems sometimes fail!

In welfare programs we also may not be aware of the automated programs that utilize electronic data transfer. However, electronic data transfer is common among state automated systems and is encouraged to reduce the burden of data entry. For example, in the JOBS Automated Systems (JAS), states are encouraged to utilize electronic data transfer to obtain demographic data on JOBS participants and their families from the AFDC automated systems. Child support enforcement utilizes electronic data transfers to obtain and exchange child support data between states. States use electronic data transfer to submit required data to the federal government to meet some of the reporting requirements for the JOBS program and the JTPA program. One could go on and on, but it is clear that electronic data transfer is here to stay and is only going to increase within and between government agencies at all levels. That being the case, there are some concerns that should be raised with regard to electronic data transfers, automated systems for program operations, and the accuracy of program operations data.

This paper is entitled, "Do we know what our computers are doing for us?" Many may think the answer is obvious. Of course we do. However, it is not clear that we do. We have conducted a number of reviews of JOBS program operations, the automated systems that support JOBS program operations, and the electronic transfer of data. These reviews have revealed that while program operations have varying amounts of erroneous data, all of them have some erroneous data.

Since this is true, then what can we do to identify the sources of erroneous data in our program operations systems? Through our program reviews, we have discovered two major sources of error: data entry and computer programming.

Data entry errors occur at the time the case manager or other welfare worker enters data into the system to create or update a case record for an individual or family. These errors are usually random in nature and may be controlled through the use of edit and consistency checks internal to the automated system. However, there will always be some data entry errors that remain on the system simply because not all such errors can be identified and corrected.

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[1] The ideas and opinions expressed in this paper are the author's own and do not necessarily represent those of the Administration for Children and Families.

Computer programming errors are much more serious in that they are systemic in nature and result in erroneous data for an entire data element or in data not being available because no data field was created to allow for the entry of the needed information. For example, our reviews of JOBS program automated systems have found the following computer programmer errors:

- In one state, the number of scheduled hours in a JOBS program component activity was not included as a data element in the automated system. This error resulted in no information being available to the case manager about the number of hours the JOBS participant was scheduled to attend.
- In another state, the computer programmer had identified a data field as alpha when it should have been numeric. This error resulted in the data field being left blank because the computer cannot accept an alpha code in a numeric field.
- In another instance, the computer programmer was directed to have the data entered in a field that required a "yes" or "no" response to default to "yes" no matter what the case manager entered into the system.

Undoubtedly, there are other programmer errors that occur. In addition, it is unknown how many errors we may be importing into the JOBS automated system from other systems such as the Family Assistance Management Information System (FAMIS). FAMIS is the program operations system for the Aid to Families with Dependent Children (AFDC) program. Demographic data on AFDC recipients who volunteer or are referred to the JOBS program is transferred electronically from FAMIS to the JOBS automated system. Thus, electronic data transfer from one program operations system to another may exacerbate the amount of erroneous data in the receiving system if the originating system does not have good controls for ensuring the accuracy of its data. It may seem that the answer to this problem is to have the data being imported by the receiving system checked and verified in some manner. However, that would not correct the original data in the system from which the erroneous data was imported.

This brings us to the key questions regarding the identification and correction of data entry and programming errors:

- Who is or should be responsible for monitoring the accuracy of the data in our program operations systems and the correctness of the computer programs which make up the program operations system?

- What is our responsibility (as users of the program operations data) to ensure the accuracy of that data?

To the extent we use program operations data for reporting purposes, we must accept some responsibility for its accuracy! This means we at the federal level, as well as those of you who have responsibility for data collection and reporting at the state or local level, must review the computer programs written to support program operations and our data collection and reporting efforts. We must work with both program policy makers and those responsible for the automated systems programming to ensure that the program operations systems are meeting the needs of the case managers, the program managers at all levels, and the needs of those outside the agency who must be provided information about the program. For example, a state JOBS program director needs to know information that will enable him or her to inform the state legislature, the governor, and other interested parties about the JOBS program and how well it is meeting the goals established for it. To the extent this data is used to make decisions about the future of the program, it must be accurate or the decision making process will be ill informed and will lead to decisions inappropriate to the program needs and the future success of the program.

How can we ensure the accuracy of program data and the correctness of the computer programs which make up the program operations system? As stated earlier, we cannot ensure the accuracy of program data and the correctness of the computer programs alone. It must be a shared responsibility with the program policy staff and the computer programming staff. We must have the cooperation of the top people responsible for these functions, and we must have them involved in the process if we are to succeed in obtaining accurate data for the management of our programs, whether it is JOBS, JTPA, child care, or any other program for which we have the responsibility to collect data and information. Therefore, we as statisticians and research analysts must take the lead to be facilitators in bringing together the program managers and the computer programmers to ask them to work with us to ensure the accuracy of the data. Otherwise, we will not be able to obtain accurate data because we do not control the original data entry nor do we control the writing of the computer programs for the automated systems to support these programs. Yet we are the ones who are held responsible for the accuracy of the data we collect and use for reporting purposes. Only through a cooperative effort will we succeed in meeting that responsibility!

Housing Symposium

Moderated by Gretchen Locke
Abt Associates, Inc.

Can Housing Assistance Be Effectively Coordinated with Support Services to Assist Families Achieve Economic Independence?

Abt Associates, Inc.

Gretchen Locke
Ingrid Gould Ellen
John Blomquist
Joseph W. Frees

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Can Housing Assistance Be Effectively Coordinated with Support Services to Assist Families Achieve Economic Independence?

Gretchen Locke, Ingrid Gould Ellen, John Blomquist and Joseph W. Frees, Abt Associates, Inc.

Operation Bootstrap is a demonstration program initiated by the Department of Housing and Urban Development (HUD) in 1989. The purpose of Operation Bootstrap is to encourage local communities to develop and implement innovative programs to assist low-income families to become economically independent through cooperative efforts of the public and private sectors. All Operation Bootstrap projects are locally designed programs offering Section 8 rental housing assistance along with a range of employability development and support services to assist low-income families achieve economic independence. HUD contributes a special allocation of Section 8 certificates and vouchers, including the associated administrative fees for the Public Housing Agency, but local Bootstrap projects are responsible for providing the other services.

Public Housing Agencies and other collaborating organizations were encouraged to design programs that reflect the particular conditions and circumstances of their own communities, including local needs and priorities, available resources, and potential collaboration among both public and private agencies and organizations. To ensure a measure of consistency and common focus among diverse local projects, and to incorporate the results of a previous demonstration program, HUD required that all local program designs, first, include a Coordinating Body to plan and implement the program, with representation from both public and private sectors, and, second, offer some combination of education and job training services, along with child care assistance, transportation assistance, personal and career counseling, and job development/job placement assistance. Other services that might be provided in Bootstrap programs include case management, life skills workshops, and support groups.

Eligibility for Operation Bootstrap was restricted to low-income families eligible for the Section 8 Program, but local programs were able to specify particular target groups, e.g., single-parent families or battered spouses. To help assure that rental assistance is effectively linked to active participation in Operation Bootstrap, local programs were encouraged to develop their own supplementary procedures to identify and select participating families on the basis of their motivation to become economically self-sufficient. However, once certificates were issued, they could not be revoked for failure to continue active participation in Operation Bootstrap.

Two allocations of Section 8 certificates and vouchers were made to support Operation Bootstrap. In 1989, HUD awarded a special allocation of 2,842 certificates to 61 local communities to support Operation Bootstrap programs; in 1990, an additional allocation of 1,135 certificates and vouchers was made to 39 of these communities. Most projects (50) are in metropolitan areas, and 22 were included in a previous HUD self-sufficiency demonstration that was funded in 1984.

Housing Symposium

In September 1991, HUD entered into a two-year contract with Abt Associates to document the results of Operation Bootstrap. The purpose of the study was not to evaluate the impact of the program on participating families, but to document its implementation in local communities, measure the progress of participants in moving toward economic independence, and identify the elements of effective programs that might serve as models for other communities.

The papers to be presented at the conference are:

- Approaches to Coordination (Joe Frees)--characterized by a high degree of local autonomy but driven by the need for collaboration with other agencies, Bootstrap projects cluster around three basic models of coordination in service delivery. This paper describes these models and the factors affecting choice of model.

- Outcomes of Participation (Ingrid Gould Ellen and John Blomquist)--relying on a follow-up telephone survey of Bootstrap participants, this paper reports on the receipt of services by participants and post-program changes in housing conditions. employment status, earnings, and dependency on public assistance. This paper will also relate variations in outcomes to different models of coordination.

- The Participant Perspective (Gretchen Locke)--drawing on the results of a series of focus group interviews with participants at ten sites, this paper looks at program design and implementation issues from the perspective of participants.

- From Demonstration to Legislation (Joe Frees)--this paper explores the early experience of local housing authorities in making the transition from the demonstration program to a broadly similar legislatively mandated program that is different in a few key elements.

For further information about the full report, please contact the authors (see address list).

Methods

Moderated by Tim Hogan, Ph.D.
Arizona State University

Parents in Transition - Felix D'Allesandro, Washington Department of Social and Health Services

Forecasting Turning Points in Welfare Caseloads: Maryland's Regional Economic Model - Michael Conte, Ph.D., Fereidoon Shahrokh, Ph.D., and Jane Staveley, M.S., University of Baltimore [Oral presentation only]

California's Longitudinal Database: A Decade of Experience on a Million Cases - Werner Schink, California Department of Social Services [Oral presentation only]

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Parents in Transition

Felix D'Allesandro, State of Washington

Executive Summary

Analysis of the transition events of leaving and returning to the welfare program indicates that many parents use the program as it is intended, quickly regaining self-sufficiency and sustaining it. Yet, there are a substantial number of parents who continue on for long spells or return frequently to the program. The parent's decision to exit or return to the program is frequently constrained by a combination of changing personal characteristics, local economies, and welfare policies. The analysis and modeling of transition events, and the processes leading to them, is providing an empirical basis for decisions on targeting resources to those with the greatest difficulty in achieving and sustaining self-sufficiency.

Personal characteristics, local economies, and welfare policy make significant and measurably independent differences in a parent's ability to achieve self-sufficiency and to sustain it.

> Older parents exited a first spell faster than younger parents and were more likely than the younger parents to sustain self-sufficiency once it was regained. Older parents still in the program at the end of the first year left at twice the rate of the younger parents. After leaving the program, younger parents returned 3 times faster than older parents.
>
> Parents in the rural CSOs exited a first spell faster than those in the urban CSOs. Monthly rates indicate that most of this difference occurred before the sixth month. The rural parents, on average, re-entered sooner with most of the difference occurring about 9 to 12 months after the parent left assistance. Rural parents do not leave a second spell as fast as they left a first spell; they leave at the same rate as urban parents in the second spell.
>
> Parents who entered a first spell at an AFDC FIP control site exited faster than those parents who entered at a FIP treatment site. In months 3 through 7 after entry, AFDC parents left 3 to 4 percent faster per month than FIP parents. There is no significant difference in re-entry based on site of first entry. In their second spell, however, AFDC parents took longer to exit; showing little difference from FIP parents.

The majority of parents leave assistance quickly and the majority of those who leave do not return. Many do both, leave quickly and do not return. A large proportion, however, will continue on either through very long single spells or through a series of recurring spells.

50 percent of the entering parents left in less than 1 year from date of entry. 53 percent of the exiting parents did not return 5 years after leaving the program.

34 percent of the entering parents left within 1 year and did not return.

One-half of the parents already on for 1 year will spend at least an additional 2 years on assistance. Also, 23 percent of the parents are in the midst of a spell that will exceed 5 years of continuous receipt; 12 percent will exceed 7 years. 39 percent of the parents who entered a first spell in March 1988 spent 2 or more spells on assistance.

Introduction

The focus of this report is on the individual parent's likelihood of leaving assistance or of returning to assistance, the transition event. The study of transition events is important due to state and federal welfare reform legislation that encourages programs that wisely *balance* the use of resources between helping a parent achieve self-sufficiency and helping that parent sustain self-sufficiency. Balance is important because policies leading to a quick exit may lead to a quick re-entry and policies leading to an ability to sustain self-sufficiency may require an extended time in the program. Measures of the likelihood of exit and the likelihood of re-entry are the most efficient quantitative gauges of the probable efficacy of program development efforts.

The study of transition events is very different than the study of time on assistance. In this analysis, transition events are examined from a dynamic perspective. The unit of analysis is the individual welfare spell as an institutionalized sequence of activities and events. The observation strategy involves mapping the flow of successive groups of entering parents through institutionally defined events (entry, face-to-face interviews, registration for employment or training, exit, re-entry, etc.) and statuses (on/off assistance). The usual study of time on assistance is undertaken from a static perspective. The unit of analysis is the distribution of months since entry for program participants at a point in time. Measures of time on assistance are usually derived from a "snapshot" of parents in the program in a particular month or year. The measures are most often calculated on open spells as opposed to completed spells. There is no assumption of measuring or observing change in most studies of time on assistance. The very essence of the study of transition events is the study of change and the factors causing that change.

The emphasis on transition events provides a link between the processes that largely determine individual decisions to leave or return and the size and composition of the program caseload. Snapshot measures of time on assistance presuppose a stable process leading to an exit or re-entry. Such measures often fall short of mirroring the actual activities that lead to a transition event. The observation strategy for the study of transition events raises the possibility of reconstructing the processes leading to a decision to exit or re-enter. The modeling of these processes provides more than just an account of outcomes; it provides a rational basis for political intervention.

Methods

The first section of this report presents different measures of welfare use. Time on and off assistance are discussed from the perspective of the observational strategy of following successive groups of parents. A more traditional presentation of time on assistance is then presented that highlights the magnitude of long term use. The second section of the report is a first pass at breaking out the actual patterns of welfare use. Welfare use by a single group of entering parents is mapped, month by month, over a four year period. A preliminary analysis of some variables representing the three major influences of personal characteristics, local economies, and welfare policies on the parents' decisions is then reported on.

Every day parents are deciding that they are more or less able to maintain a self-sufficient lifestyle. The decision is reached because something changed. It could have been a personal characteristic, a development in the local economy, or a service or benefit provided by the state. The research reported on in this paper can be a first step in providing an empirical basis for decisions on targeting resources to help those with the greatest difficulty in achieving and sustaining self-sufficiency.

Data and Methods

The findings in this report are preliminary and are presented as a first pass from an effort to develop data and methods that mimic the actual patterns of welfare use. The analysis is based on the individual welfare histories of the parents of dependent children who have been on assistance at any time since 1985. The data are developed from an extract off the Medical Management Information System (MMIS). Due to the foresight of the Washington State Office of Financial Management who maintain an extended MMIS database, for most of these parents, histories are available back to 1982.

Only the adult portion of a welfare history is considered. A parent must have been off assistance, that is, without receipt of a grant, for three months to be considered eligible to be an entrant. A special case of entrants is considered in this report. Parents who have no record of receipt for at least 60 months are considered first time recipients. A spell of assistance continues through time from entry to AFDC until exit from any grant receipt.

Findings

The analysis of individual welfare histories has identified a very dynamic AFDC program in Washington; monthly turnover in the AFDC programs is relatively high. Every month, many parents experience a transition event, either leaving or returning to assistance.

> During the recent fiscal year, in the one parent program, on average, 2,750 parents entered each month, over 1,400 of these parents, 51.5 percent, are starting a first spell. The number of entries is up from an average of 2,500 five years ago.
>
> Exits are currently averaging 2,569 per month, up from 2,260 five years ago.

In the two parent program, 1,738 parents are entering each month. Over 1,000 of these parents, 58 percent, are first time entries.

Exits in the two parent program are typically about 1,280 per month, up from 1,150 per month five years ago.

This finding contrasts with notions that a large group of parents are entrenched in a lifetime of welfare use. State and national studies report that families from all levels of society, from the whole range of incomes, were found to spend time on assistance caseloads.

In this study, data support the following observations:

Over one-half of the parents entering AFDC leave within 12 months.

The majority of parents who leave assistance do not return.

Many parents, 25 to 35 percent, do both, leave quickly and do not return.

A snapshot look at time on assistance understates the eventual time on for long term recipients.

On a monthly basis:

Parents are more likely to exit if they have not been on very long.

Parents are more likely to re-enter if they have not been gone very long.

Age at first entry does impact the likelihood of a decision to exit or re-enter; younger parents are less likely to exit and more likely to return than older parents.

The local economy does impact the decision to exit or re-enter; parents in rural areas tend to exit sooner and re-enter sooner than parents in urban areas.

Welfare policy is an important part of the decision to exit or re-enter; parents in FIP treatment sites took longer to exit than the parents in the AFDC control sites yet returned to assistance at about the same rate.

The timing of exit and re-entry to assistance for groups of parents entering or leaving appears to follow predictable patterns. These patterns are now being charted with a high degree of accuracy. Personal characteristics, local economies, and state welfare policies are found to influence the individual decisions that lead to the timing of exits and re-entries. Knowledge of these patterns can undergird effective public policy intervention. The methods in this study provide an empirical link between program impact for individual parents and the budget allotted to run the program. The cumulation of the individual decisions accounts for the size and composition of the program caseload.

Measures of Welfare Use

The focus on process is revealing that many of the parents use the program as it is intended, quickly regaining self-sufficiency and sustaining it. The majority of the parents leave assistance quickly and the majority of those who leave do not return. A smaller but impressive proportion of the parents do both; leave quickly and do not return. For these parents enrollment in a welfare program serves as a period of transition between self-sufficient lifestyles.

The same focus on process also reveals the difficulty that some parents face in achieving self-sufficiency and sustaining it. As often as not, a parent currently enrolled in the welfare program will spend at least another year and one-half in the program before leaving. The barriers to self-sufficiency apparently become more difficult to overcome as the parent spends more time on assistance. A substantial proportion of the parents who achieved a measure of self-sufficiency found it difficult to sustain. Parents were identified as long term users both as a result of long single spells and a series of recurring spells.

Time On Assistance

Time, measured as time to exit, forces attention on the processes of entry, accommodation to the welfare system, and exit. Identifying the factors, especially those that lead to the transition event and are amenable to public policy, argues for spell length measures rather than point-in-time measures.

> 52 percent of the parents entering the one parent program leave assistance during the first year. Parents entering with and without welfare histories were followed for five years.(Chart 1)
>
> The parents who do not exit quickly accumulate to become a sizeable proportion of the program; 66 percent of the parents have been on over one year, when measured at a point in time. (Chart 3)
>
> A snapshot look at time on assistance yields only a partial picture of the true time spent on assistance for the parents currently in the program. One-Half of the parents already on for one year will go on to spend at least an additional two years on assistance. Also, 23 percent of the parents are in the midst of a spell that will exceed 5 years of continuous receipt; 12 percent will exceed 7 years. (Chart 3)

Time Off Assistance

Nearly 53 percent of the parents in the one parent program will not return to assistance after five years. Some of these parents are leaving after having spent long periods on assistance; some after spending short periods. Some of these parents are leaving after a first spell of assistance; some after several spells. (Chart 2)

Do Those Parents Who Leave Quickly Stay Gone?

Parents who left a first spell were identified on the basis of whether they left in six months or less or twelve months or less. These parents were then tracked for several years to study the re-entry patterns of those who leave after a short stay in the program. The sooner a parent leaves assistance the less likely that parent is to return to the program.

Nearly 34 percent of the parents who began a first spell of assistance in March 1988 left the program in six months or less. After more than three years since their exit from the program over two-thirds were still gone. 23 percent of the entering parents left very quickly and did not return.

Nearly 53 percent of the parents who began a first spell of assistance in March 1988 left the program in twelve months or less. After three years since their exit from the program over 65 percent were still gone. 34 percent of the entering parents left quickly and did not return.

Multiple Spells

Although the intention is to assist parents in stabilizing their life situation quickly, not all crises are amenable to a quick fix that can be sustained.

47 percent of the parents who left assistance between July 1985 and June 1986 returned to assistance over the subsequent five years. (Chart 2)

39 percent of the parents who entered a first spell in March 1988 spent two or more spells on assistance. (Chart 4)

Detailed analysis of multiple spells is hampered by a lack of adequate data and methods to do the analysis. The major bias in analyzing multiple spells of assistance with only four or five years of data is that the welfare histories have only had time to record short spells of receipt and short spells off the program.

Methods

Detailed Analysis

The next step, however, is to systematically follow the welfare use of a group of parents who all entered a first spell of assistance together in March 1988. March 1988 parents were chosen because they have been studied and extensively reported on by the Washington State Institute for Public Policy at Evergreen State College. The Institute's study provides a lot of information on the personal characteristics and behavior of parents that is not available to this study.

Modeling Actual Patterns of Welfare Use (Chart 5, Top Row)

In March 1988, 1,283 parents started receiving AFDC for the first time through the one parent program. Welfare use data were collected for these parents over the following 46 months. Each month, some left assistance. Over the 46 months, 1,090 parents, nearly 85 percent of the entering group, eventually left.

> 50 percent of the parents entering a first spell in the one parent program left in 12 months

Over the course of the study, 368 of the parents returned to start a second spell of assistance. Parents returning amounted to 29 percent of the group that entered a first spell in March 1988. Some of these parents had been off assistance for three months; some for over 40 months. Altogether, 34 percent of those who left came back.

> 25 percent of the parents who left a first spell of assistance returned within 17 months; 66 percent did not re-enter after 46 months

Before the end of data collection, 223 parents left a second spell of assistance. Some of these parents would go on to enter and exit several additional spells.

> 50 percent of the parents entering a second spell in the one parent program left in 12 months

Tracking Transition Events (Chart 5, Bottom Row)

The measure of a transition event is the percentage of the parents faced with a decision to exit or re-enter each month who go ahead and do it. This measure is often called the individual chance, likelihood, or probability of exit or re-entry. An important part of this measure is that the percentage is calculated on the number of parents who start the month on or off assistance. The distinction of this measure is that it is not based on the number who started in March.

> Time on assistance is associated with a lower chance of leaving the program.

Close examination of the monthly likelihood of exit finds a pattern of parental decisions that is anything but constant. Generally, the chance of leaving a first spell is high during the first several months after entry, usually peaking about the seventh month. The chance of leaving shows a regular decline after the initial period. Analysis will focus on the several noticeable peak months of exit.

Time off assistance is associated with a lower chance of returning to the program.

Re-entry decisions are amenable to the same sort of analysis. The peak chance of re-entry is in the third or fourth month after exit. A regular decline in the chance of returning to the program then sets in.

Monthly exit rates for the second spell do not show the regular pattern. This observation can be attributed mostly to the small number of parents in the study who started and completed a second spell. In another analysis, using a larger number of parents, the pattern of declining exit probabilities in the second spell was found.

Why might time determine the chance of transition?

The impact of the factors influencing the parent's decision to leave assistance or not, at the time of first entry, is linked to the personal crisis that brings the parent to the CSO. The chance of leaving during the first months on assistance is very much determined by the parents ability to overcome the crisis that brought him or her in. The CSO helps parents seek their place in the local economy. For parents who cannot make a quick adjustment to regain self-sufficiency, there begins a series of accommodations to department procedures and regulations. As time since entry increases, continued receipt of assistance changes its focus from the crisis that brought the parent into the CSO to the parent's ability to continue meeting eligibility requirements.

Time, then, is often used as an indicator of the chance of moving off or back onto assistance. The use of time in this fashion may be mostly due to convenience -- it is often the only reliable piece of data available. A very good argument can also be made that parents enter the program with a definite chance of leaving within so many months and that this chance does not change as a result of being on assistance. Those who are going to leave fast, leave fast; those who are not, don't. Over time, those who never had a high probability of exit are the only ones remaining. Another interpretation is that there are factors that operate through time that determine transition rates. Identifying these factors, and their differential impact, is the goal of analysis.

If not time, then what?

The monthly rise and fall of a parent's likelihood of a transition event may reflect the conjunction of the differential influence of personal characteristics, local economies, and welfare policies. Preliminary analysis of the first spell, first time off assistance, and second spell in the context of variables illustrating personal characteristics, local economies, and welfare policies indicates that these major influences affect exit and re-entry rates. While statistically significant findings were found for some of the reported differences, much caution should be exercised in assessing the substantive significance of the preliminary analyses represented in these charts.

Factors Influencing Transition Events

First Spells (Chart 6)

Parents who are over age 24 at first entry exit faster than those parents under age 24. The monthly exit rates show the greatest difference for the two age groups is at the end of the first year.

Parents in the rural CSOs exit faster than those in the urban CSOs. The monthly rates indicate that the bulk of this difference occurs before the sixth month with a tendency for the exit rate to slow down later on.

Parents who entered in AFDC control sites exit faster than those parents entering in FIP treatment sites. Just about all the difference can be assigned to program differences in months three through seven.

First Time Off Assistance (Chart 7)

Parents who were under age 24 at first entry, who left assistance and returned for a second spell, re-entered at three times the rate of the older parents. The monthly differences in re-entry rates are especially large in the first 10 months after leaving the first spell.

Parents in the rural CSOs re-enter sooner than parents in the urban CSOs. The monthly re-entry rates indicate most of the difference occurs about 9 to 12 months after the parent left assistance.

There is no significant difference based on site of first entry for those parents who entered in an experimental site.

Second Spells (Chart 8)

Many of the differences between identified subgroups disappear during the second spell. The biggest reason for this finding may be the small number of cases starting second spells that started a first spell in March 1988.

Support for this reasoning comes from the third panel which compares parents in AFDC and FIP experimental sites. A much larger group of parents was tracked in this analysis. The monthly exit rates follow the more predictable pattern. The finding is that there is no significant difference in the exit rates between the two groups.

Comparison of time to exit between first and second spells indicates 12 months are required for 50 percent of the parents to exit the program. (Chart 5) Parents in rural CSOs left assistance faster in their first spell than in their second spell. Parents who entered in AFDC spells left assistance faster in their first spell than they did in their second spells; showing little difference from FIP parents during the second spell. (Charts 6 and 8)

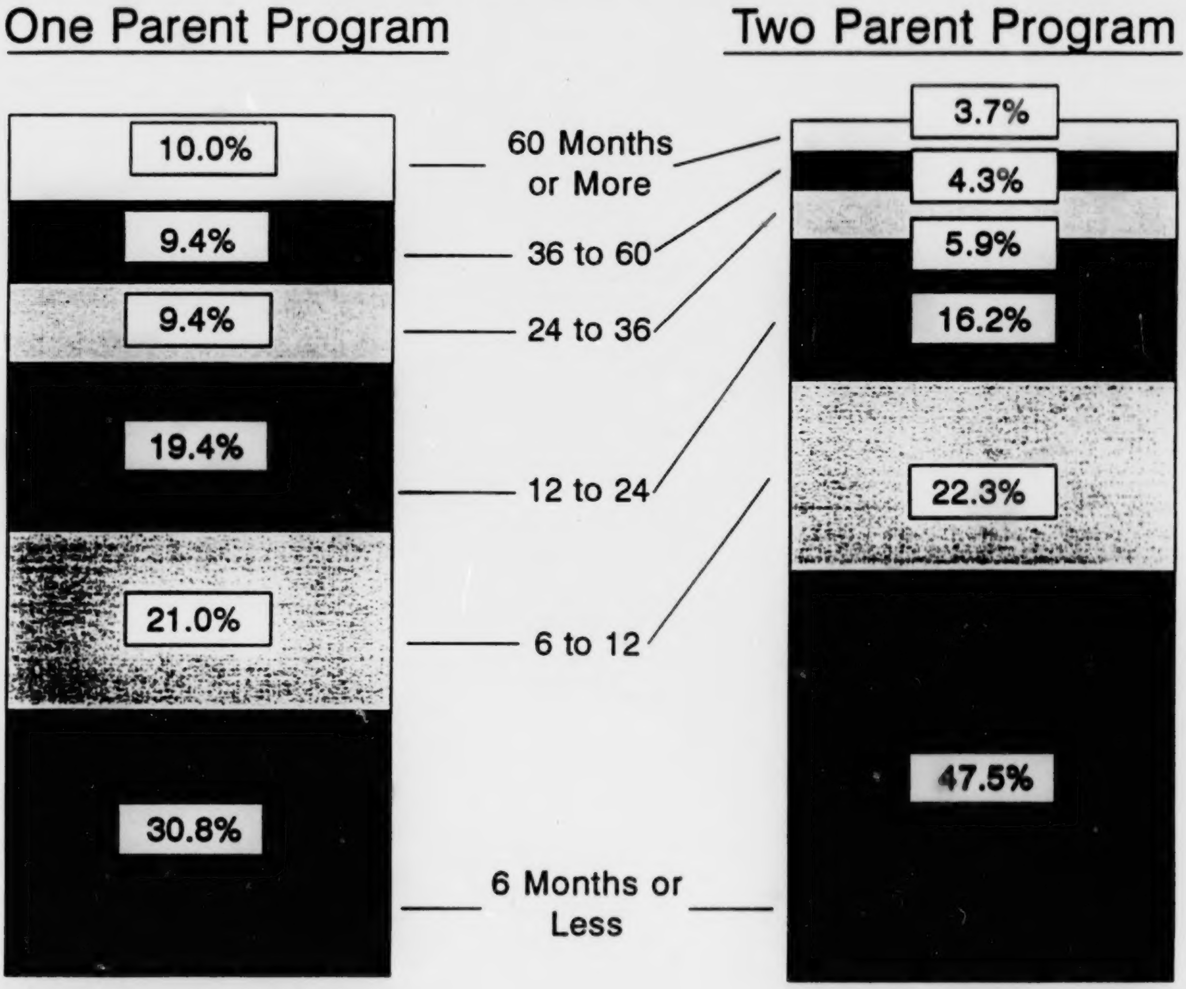
Time on Assistance, Exit/Re-Entry Rates, and Welfare Policy

The message of this report is that policy analysis focused on transition events, individual level exit and re-entry probabilities, powerfully focuses attention on options that were not accessible through data and methods before. Time since entry or exit is a good shorthand predictor of exit or re-entry. Time, however, does not cause the likelihood of exit or re-entry. Personal characteristics, local economies, and welfare policies operate through time to determine whether a parent will decide to exit or re-enter in any particular month. A statistical measure of the outcomes of this decision process is the chance, or probability, of exit or re-entry. Identification and subsequent modeling of these factors will benefit the targeting of resources. Targeting, based solely on personal characteristics, may miss the mark of maximizing the self-sufficiency of parents of dependent children.

Chart 1

The Majority of Entering Parents Leave Assistance Within 12 Months

This chart reports the percentage of parents who left assistance after a number of continuous months of grant receipt. The data are based on those parents who entered during the 12 months between July 1985 and June 1986. The personal characteristics of the parents, the changing opportunities of the local economies, and the changing welfare policies operated over the five plus years to differentially impact the parent's decision to leave assistance.



50 percent of the parents left public assistance within 11.4 months.

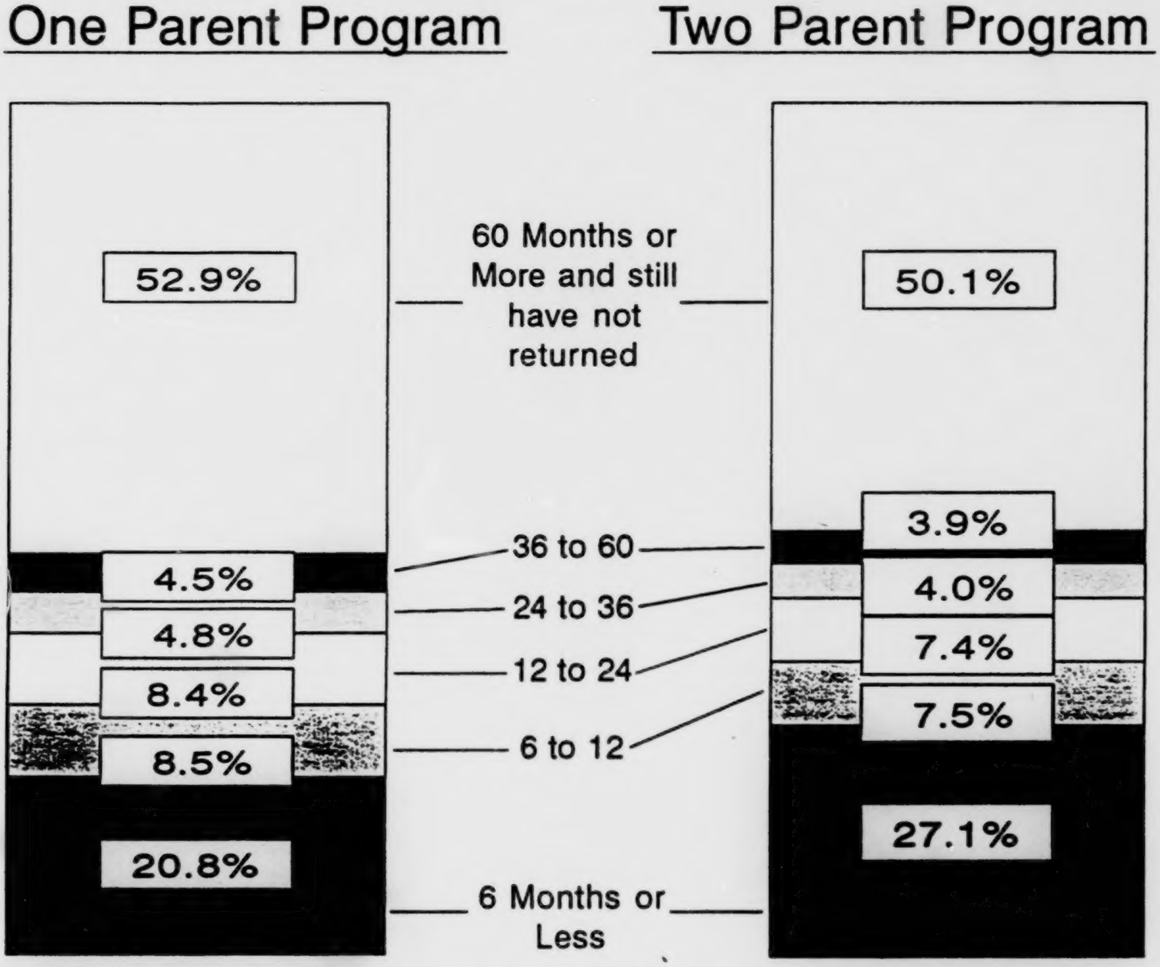
50 percent of the parents left public assistance within 6.2 months.

To leave assistance means: 1) Off for three months; 2) may exit through other than origin program. Data include both first time entries and reentries.

Chart 2

The Majority of Exiting Parents Do Not Return to Assistance

This chart reports the percentage of parents who returned to assistance after a number of continuous months without grant receipt. The data are based on those parents who exited during the 12 months between July 1985 and June 1986. The personal characteristics of the parents, the changing opportunities of the local economies, and the changing welfare policies operated over the five plus years to differentially impact the parent's decision to return to assistance.



25 percent of the parents returned to public assistance within 9.0 months.

25 percent of the parents returned to public assistance within 5.5 months.

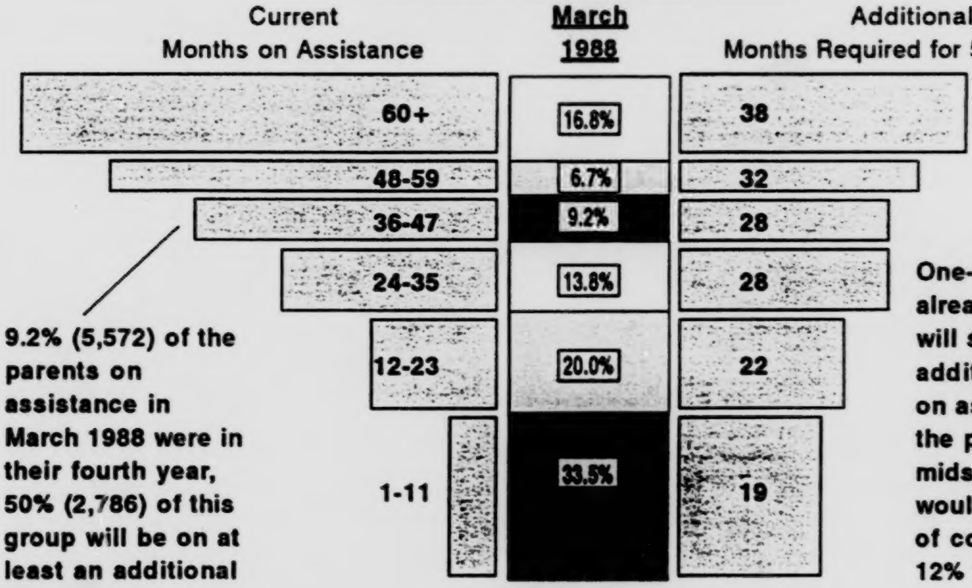
To reenter assistance means: 1) having been off for at least three months; 2) may reenter through other than program at exit. Data include the full range of welfare histories at exit.

Chart 3

Parents Who Do Not Exit Quickly Often Become Long Term Recipients

This chart reports time on assistance for parents who received a grant in March 1988. The snapshot, shown in the center bargraph, requires extensions to spell beginnings and endings to yield a complete account of welfare use. Policy strategies for long term recipients can gain an empirical base through knowledge of the factors, operating through time, that impact the parent's decision to leave assistance.

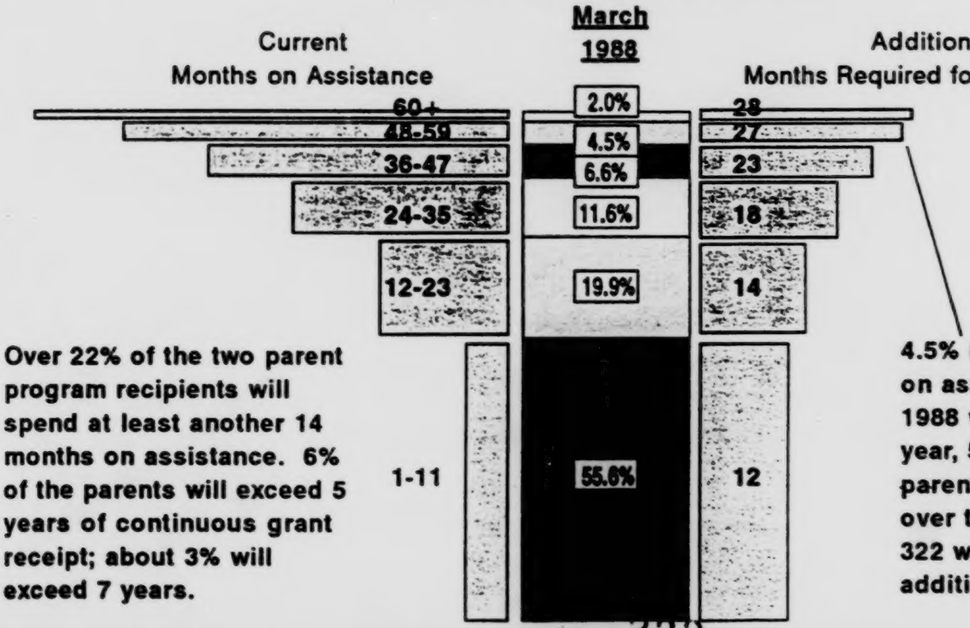
One Parent Program



9.2% (5,572) of the parents on assistance in March 1988 were in their fourth year, 50% (2,786) of this group will be on at least an additional 28 months.

One-half of the parents already on for 1 year will spend at least an additional 22 months on assistance. 23% of the parents were in the midst of a spell that would exceed 5 years of continuous receipt; 12% will exceed 7 years.

Two Parent Program



Over 22% of the two parent program recipients will spend at least another 14 months on assistance. 6% of the parents will exceed 5 years of continuous grant receipt; about 3% will exceed 7 years.

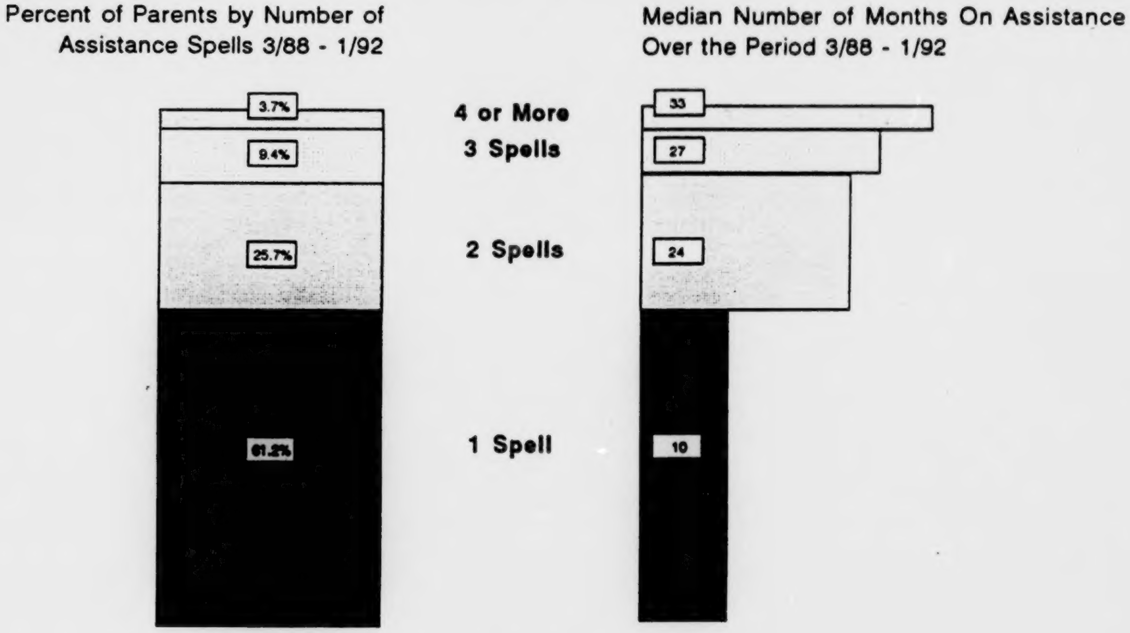
4.5% (644)of the parents on assistance in March 1988 were in their fifth year, 50% (322) of these parents left assistance over the next 27 months, 322 were on at least an additional 27 months.

Chart 4

Parents May Leave Quickly and Return Becoming Long Term Recipients Through Multiple Spells

This chart reports the percentage of parents who received assistance for the first time in March 1988 by the number of spells and total time on assistance. Parents who repeatedly return to the program have not yet escaped at least partial dependence. But, they did achieve some measure of self-sufficiency. A welfare history becomes an additional factor that may structure a parent's decision to return to assistance or to again exit.

One Parent Program



Two Parent Program

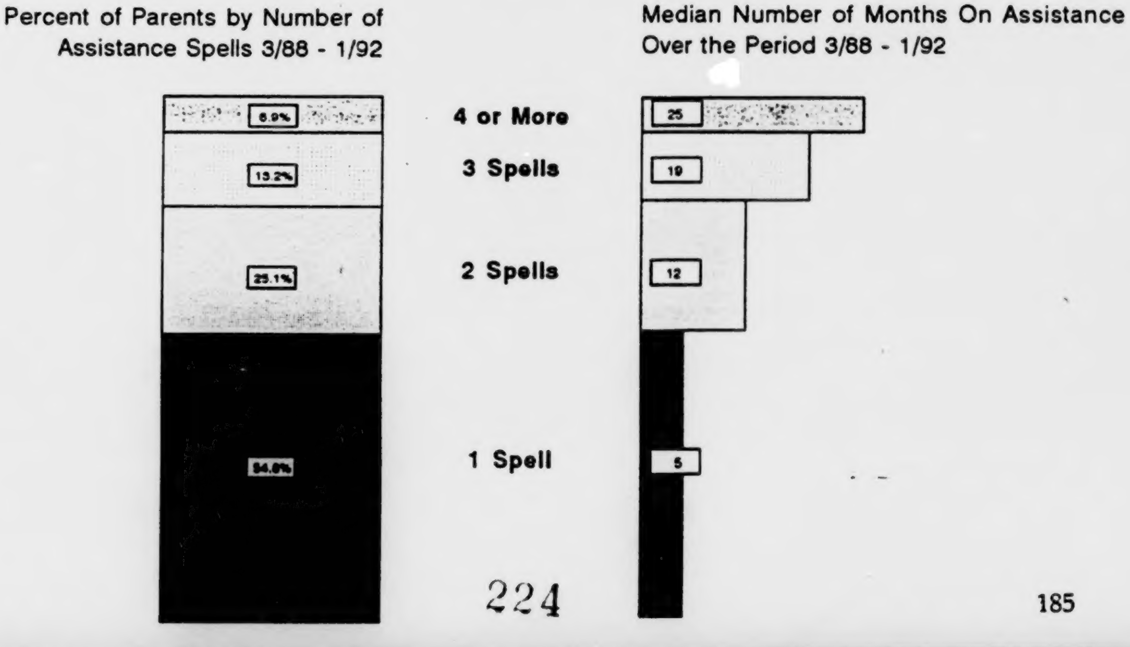
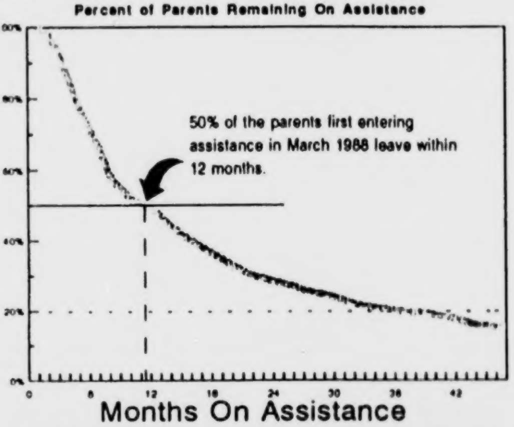


Chart 5
Time On Assistance: A Detailed Look At Exit and Re-Entry
The One Parent Program

Modeling Actual Patterns of Welfare Use

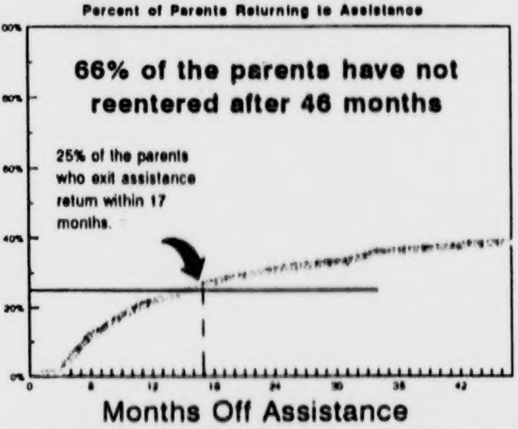
Parents Entering AFDC for the First Time in March 1988


Percent of Parents Remaining On Assistance

50% of the parents first entering assistance in March 1988 leave within 12 months.

1,283 Parents entered the program in March 1988. They had no record of grant receipt over the previous 60 months. During the next 46 months, 1,090 (85%) left assistance.

First Time Off Assistance for Parents Who Entered in March 1988

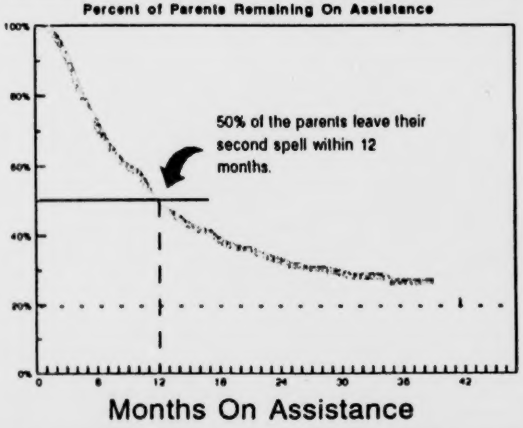

Percent of Parents Returning to Assistance

66% of the parents have not reentered after 46 months

25% of the parents who exit assistance return within 17 months.

1,090 parents left assistance between April 1988 and December 1991. 368 parents, 34% of those who left, returned to start a second spell of assistance.

Second Time On Assistance for Parents Who Entered in March 1988

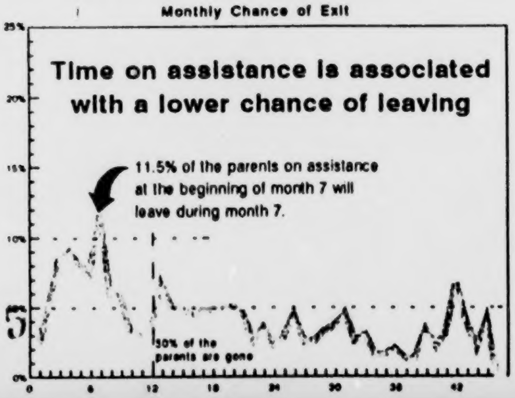

Percent of Parents Remaining On Assistance

50% of the parents leave their second spell within 12 months.

368 parents, 29% of the original 1,283, started a second spell. 223 parents (61%) left their second spell during the study period. Some of these parents entered and exited several additional spells.

Tracking Transition Events

First Time On Assistance

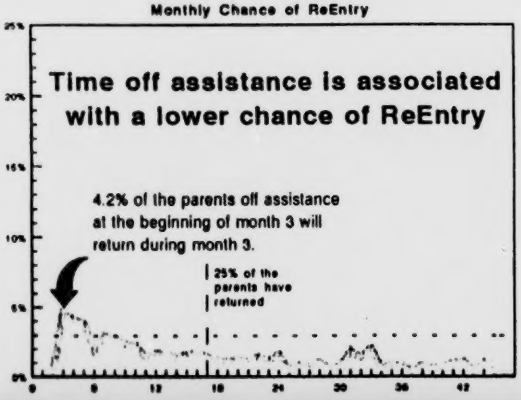

Monthly Chance of Exit

Time on assistance is associated with a lower chance of leaving

11.5% of the parents on assistance at the beginning of month 7 will leave during month 7.

30% of the parents are gone

First Time Off Assistance

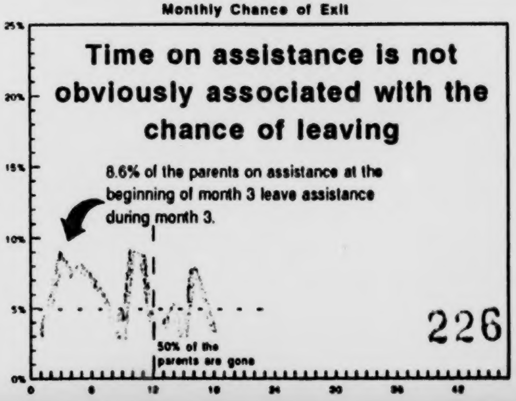

Monthly Chance of ReEntry

Time off assistance is associated with a lower chance of ReEntry

4.2% of the parents off assistance at the beginning of month 3 will return during month 3.

25% of the parents have returned

Second Time On Assistance


Monthly Chance of Exit

Time on assistance is not obviously associated with the chance of leaving

8.6% of the parents on assistance at the beginning of month 3 leave assistance during month 3.

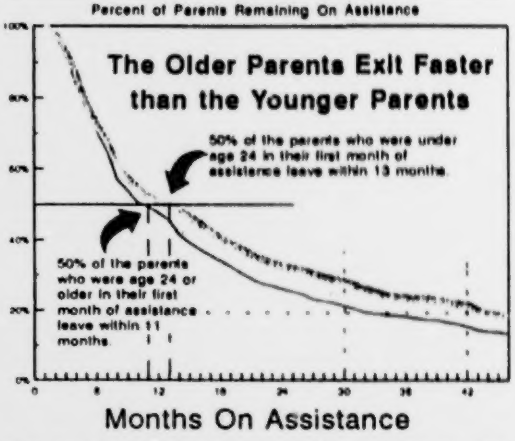
50% of the parents are gone

Chart 6

Many Factors Affect the Chance of Leaving a First Spell
The One Parent Program

Modeling Actual Patterns of Welfare Use

Age When Entering AFDC for the First Time in March 1988



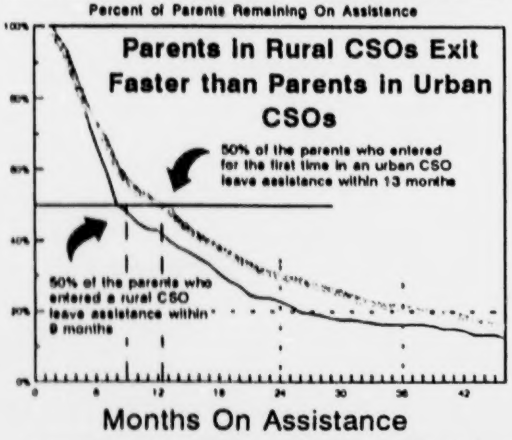
The Older Parents Exit Faster than the Younger Parents

50% of the parents who were under age 24 in their first month of assistance leave within 13 months.

50% of the parents who were age 24 or older in their first month of assistance leave within 11 months.

491 (38%) parents were under age 24 at the start of their first recorded spell of AFDC. The remaining 792, were age 24 or over. The impact of age becomes most apparent at the end of the first year.

Local Economy When Entering AFDC for the First Time in March 1988



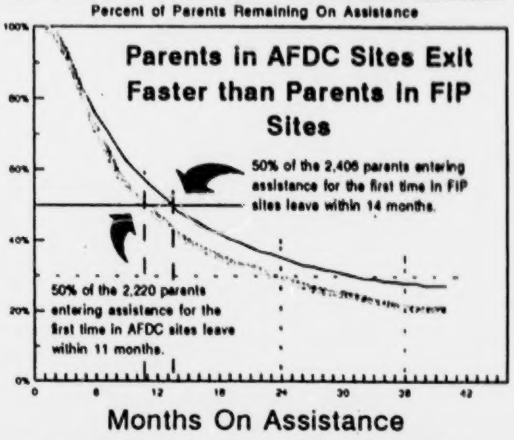
Parents in Rural CSOs Exit Faster than Parents in Urban CSOs

50% of the parents who entered for the first time in an urban CSO leave assistance within 13 months

50% of the parents who entered a rural CSO leave assistance within 9 months

1,052 Parents (82%) started their first spell of AFDC in an urban CSO. 231 Parents started in a rural CSO. The impact of a local economy is very important in the first six months.

Demonstration Site When Entering AFDC for the First Time in 10/88 - 9/89



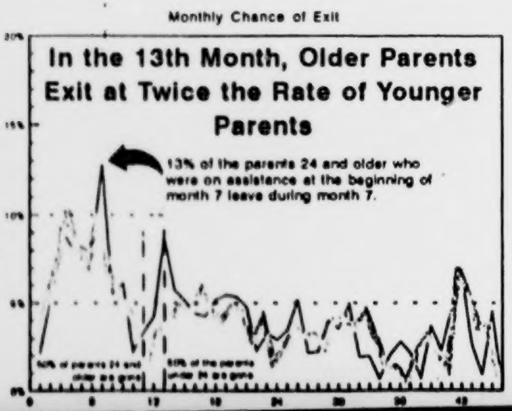
Parents in AFDC Sites Exit Faster than Parents in FIP Sites

50% of the 2,406 parents entering assistance for the first time in FIP sites leave within 14 months.

50% of the 2,220 parents entering assistance for the first time in AFDC sites leave within 11 months.

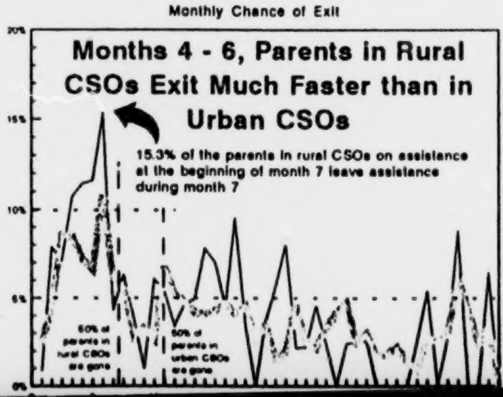
2,406 Parents started their first spell of AFDC at a FIP site. 2,220 started at an AFDC site. The program differences have their strongest impact in months 3 through 8.

Tracking Transition Events



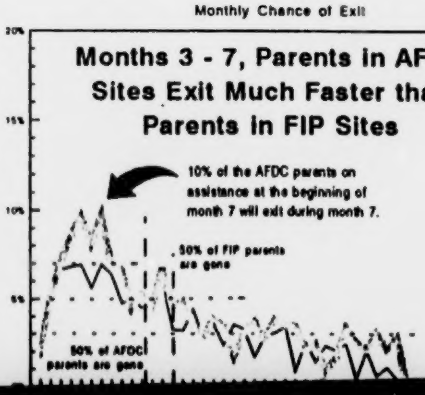
In the 13th Month, Older Parents Exit at Twice the Rate of Younger Parents

13% of the parents 24 and older who were on assistance at the beginning of month 7 leave during month 7.



Months 4 - 6, Parents in Rural CSOs Exit Much Faster than in Urban CSOs

15.3% of the parents in rural CSOs on assistance at the beginning of month 7 leave assistance during month 7



Months 3 - 7, Parents in AFDC Sites Exit Much Faster than Parents in FIP Sites

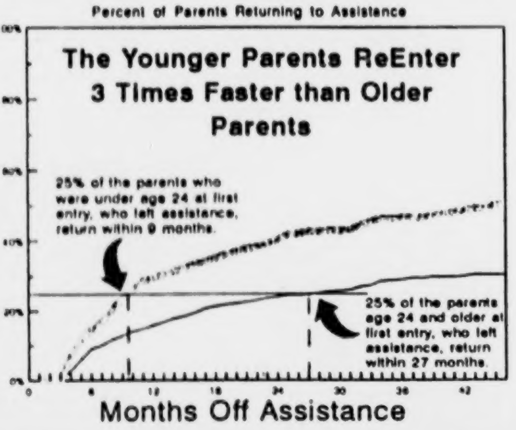
10% of the AFDC parents on assistance at the beginning of month 7 will exit during month 7.

Chart 7

Many Factors Affect the Chance of ReEntering Assistance The One Parent Program

Modeling Actual Patterns of Welfare Use

Age When Entering AFDC for the First Time in March 1988



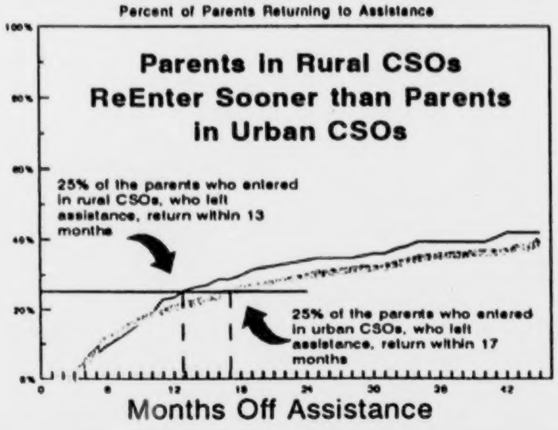
The Younger Parents ReEnter 3 Times Faster than Older Parents

25% of the parents who were under age 24 at first entry, who left assistance, return within 9 months.

25% of the parents age 24 and older at first entry, who left assistance, return within 27 months.

403 (82%) parents under age 24 at the start of their first spell left AFDC during the study period. 687 (87%) age 24 or over also left. The impact of age at first entry on reentry increases with time.

Local Economy When Entering AFDC for the First Time in March 1988



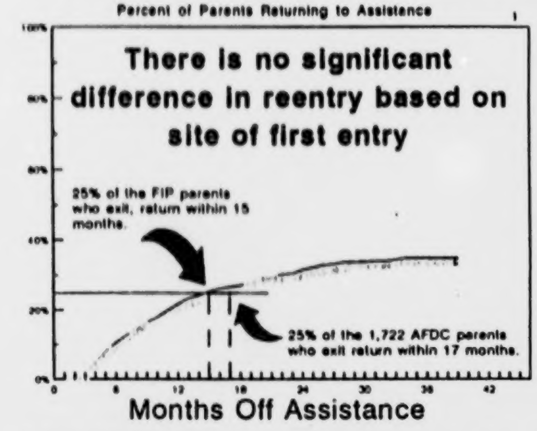
Parents in Rural CSOs ReEnter Sooner than Parents in Urban CSOs

25% of the parents who entered in rural CSOs, who left assistance, return within 13 months

25% of the parents who entered in urban CSOs, who left assistance, return within 17 months

201 Parents (87%), in rural CSOs at first entry, left AFDC during the study period. 885 (84%), in urban CSOs at entry, also left. The impact of CSO size on chance of re-entry is time delayed.

Demonstration Site When Entering AFDC for the First Time in 10/88 - 9/89



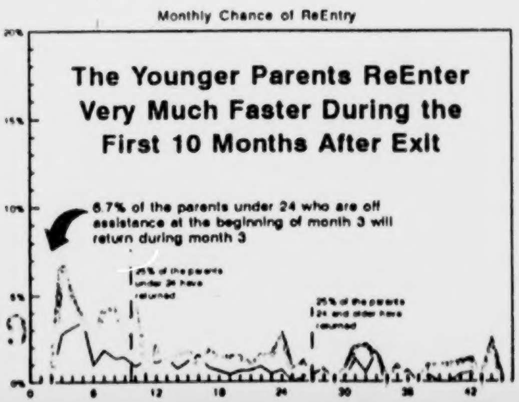
There is no significant difference in reentry based on site of first entry

25% of the FIP parents who exit, return within 15 months.

25% of the 1,722 AFDC parents who exit return within 17 months.

1,716 (71%) Parents, in FIP sites at first entry, left AFDC during the study period. 1,722 (78%), in AFDC sites at entry, also left. The program differences do not appear to affect the chance of reentry.

Tracking Transition Events

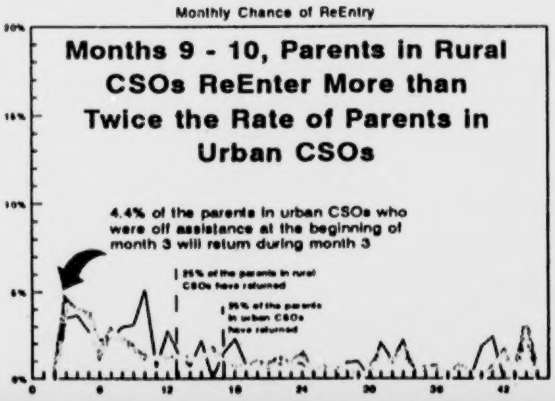


The Younger Parents ReEnter Very Much Faster During the First 10 Months After Exit

6.7% of the parents under 24 who are off assistance at the beginning of month 3 will return during month 3

25% of the parents under 24 have returned

25% of the parents 24 and older have returned

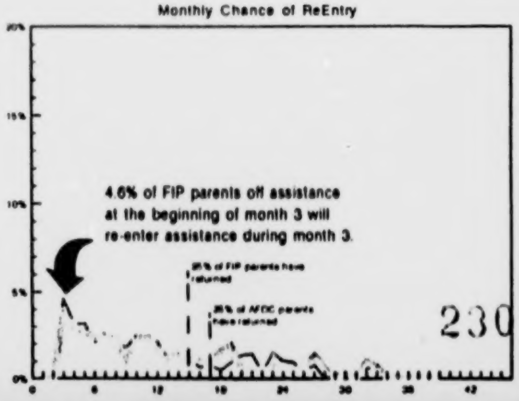


Months 9 - 10, Parents in Rural CSOs ReEnter More than Twice the Rate of Parents in Urban CSOs

4.4% of the parents in urban CSOs who were off assistance at the beginning of month 3 will return during month 3

25% of the parents in rural CSOs have returned

25% of the parents in urban CSOs have returned



4.6% of FIP parents off assistance at the beginning of month 3 will re-enter assistance during month 3.

25% of FIP parents have returned

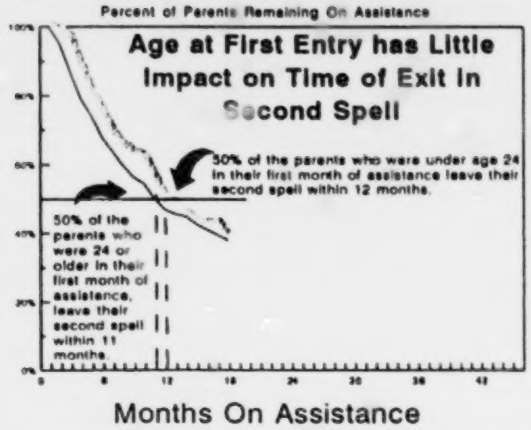
25% of AFDC parents have returned

Chart 8

Many Factors Affect the Chance of Leaving a Second Spell The One Parent Program

Modeling Actual Patterns of Welfare Use

Age When Entering AFDC for the First Time in March 1988



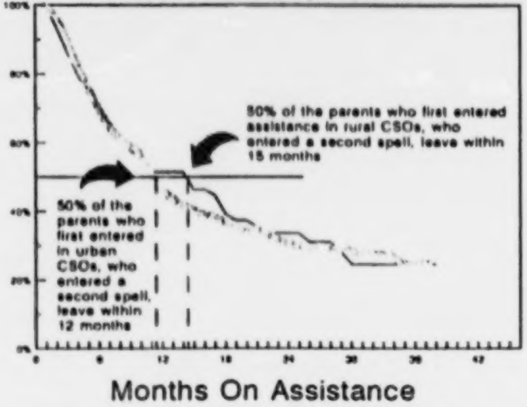
Age at First Entry has Little Impact on Time of Exit in Second Spell

50% of the parents who were under age 24 in their first month of assistance leave their second spell within 12 months.

50% of the parents who were 24 or older in their first month of assistance, leave their second spell within 11 months.

178 Parents, 36% of those who started a first spell under age 24, started a second spell. 190 Parents, only 24% of those starting over age 23, started a second spell.

Local Economy When Entering AFDC for the First Time in March 1988

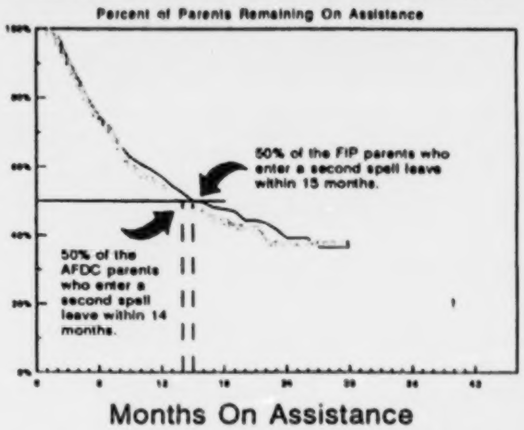


50% of the parents who first entered assistance in rural CSOs, who entered a second spell, leave within 15 months

50% of the parents who first entered in urban CSOs, who entered a second spell, leave within 12 months

76 Parents, 33% of those who started a first spell in a rural CSO, started a second spell. 292 Parents, 28% of those starting a first spell in an urban CSO, started a second spell.

Demonstration Site When Entering AFDC for the First Time in 10/88 - 9/89

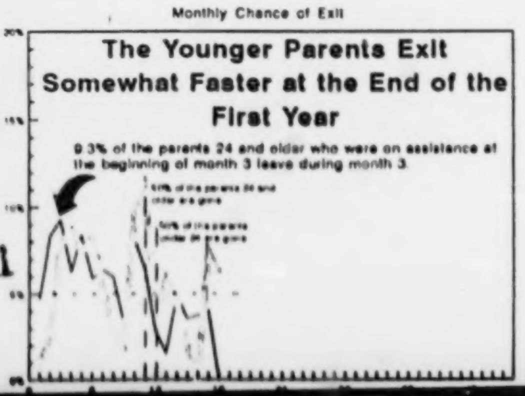


50% of the FIP parents who enter a second spell leave within 15 months.

50% of the AFDC parents who enter a second spell leave within 14 months.

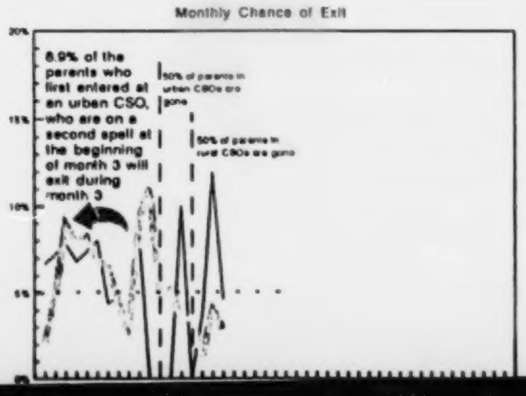
514 Parents, 21% of those who started a first spell in a FIP site, started a second spell. 495 Parents, 22% of those starting a first spell in an AFDC site, started a second spell.

Tracking Transition Events

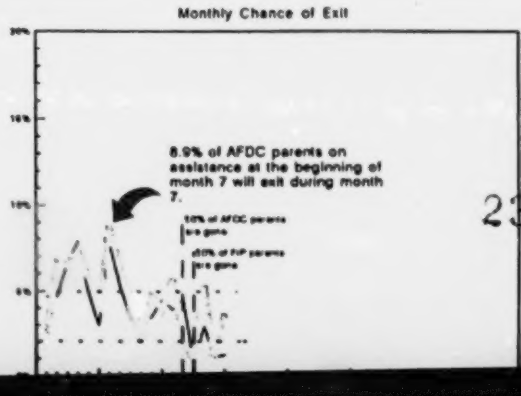


The Younger Parents Exit Somewhat Faster at the End of the First Year

9.3% of the parents 24 and older who were on assistance at the beginning of month 3 leave during month 3.



8.9% of the parents who first entered at an urban CSO, who are on a second spell at the beginning of month 3 will exit during month 3



8.9% of AFDC parents on assistance at the beginning of month 7 will exit during month 7.

Forecasting Turning Points in Welfare Caseloads: Maryland's Regional Economic Model

Michael Conte, Ph.D., Fereidoon Shahrokh, Ph.D., and Jane Staveley, M.A., University of Baltimore, Department of Economics

An econometric model of the Maryland AFDC caseload was developed to provide accurate forecasts of monthly AFDC caseloads and to simulate the impact of policy changes on the caseload. The principal contribution of this model is its ability to forecast changes in caseload trends, unlike other models, which are able to estimate a single trend but have great difficulty in forecasting turning points in the trend. The Maryland Econometric Model consists of a series of sub-models, each representing different aspects of economic activity but each interrelated with the others. The AFDC Gross Flow Model was used to derive a single regression model, the AFDC Net Flow Model. The discussion focuses on the methodological issues in developing the models.

For further information on the full report, please contact the authors (see address list).

California's Longitudinal Database: A Decade of Experience on a Million Cases

Werner Schink, California Department of Social Services

California is building a longitudinal database of AFDC, Food Stamp, MediCal and Wage Histories for a 10 percent sample of its welfare recipients. The database development effort is central to California's Assistance Payment Demonstration Project and to a better understanding of the dynamics of the state's multi-cultural and multi-ethnic population. What is it? How are we building it? What are we going to do with it?

For further information on the database, please contact the author (see address list).

Pregnancy and Parenting among Teens

Moderated by Richard Hough, Ph.D.
San Diego State and University of California

Adolescent versus Older Mothers: Type, Perpetrator, and Severity of Child Maltreatment - Diane DePanfilis and Susan J. Zuravin , University of Maryland at Baltimore, and Katya Masnyk, University of Toronto

Toward a Conceptual Clarification of Teen-Age Pregnancy: A Beginning Step for a Social Action Agenda - Ellwyn R. Stoddard, Ph.D., University of Texas at El Paso

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Adolescent versus Older Mothers: Type, Perpetrator, and Severity of Child Maltreatment

Diane DePanfilis and Susan J. Zuravin, University of Maryland at Baltimore, and Katya Masnyk, University of Toronto

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Abstract

Research on the parenting behaviors of adolescent mothers suggests that they care for their infants less adequately than older mothers and may be at higher risk for child maltreatment. This article reports findings from a study of 799 inner city (primarily poor) families that examined differences between adolescent and older mothers with respect to type, perpetrator, and severity of child physical abuse and neglect. Results revealed many differences between the maltreated children of adolescent and older mothers. The children of adolescent mothers were more likely to be neglected, more likely to sustain serious injuries from abuse and adverse consequences due to neglect, and more likely to be the victims of nutrition and physical health care neglect as well as multiple types of neglect. On the other hand, the children of older mothers were more likely to be abused and to be the victims of multiple supervisory and mental health care neglect. Discussion focuses on recommendations for future research.

Introduction

National statistics estimate that every year approximately 500,000 adolescent females give birth (Hayes, 1987). Research on the parenting practices (e.g., Ellster, McArnarney, and Lamb, 1983) of these young mothers suggests that they care for their infants less adequately than older mothers and may be at higher risk for child maltreatment (e.g., Stier, et. al., 1993).

Despite recent national interest in the relationship between adolescent child bearing and child maltreatment, we don't know very much about the nature and extent of maltreatment experienced by children of adolescent mothers compared to children of older mothers. For example, are children of adolescents more likely to be neglected or abused? Who are we trying to prevent from abusing - the mother, father, babysitters? Of the many sub-types of neglect, which of them are children of adolescents mothers more likely to experience? And, how serious are the consequences of maltreatment for the children of adolescents compared to maltreatment of children of older mothers?

A search of the literature for even the most tentative of answers to these questions identified only three relevant studies (Bolton and Laner, 1981; Miller, 1984, Stier, et. al., 1993.) Their findings revealed differences between adolescent and older mothers with respect to type, perpetrator, and severity of maltreatment. All three studies found neglect to be more common than physical abuse among the maltreated children of adolescent mothers. In addition, Bolton and colleagues (1980) found that as mother's age increased, the rate of substantiated abuse increased, that the proportion of mother perpetrators decreased while the proportion of male perpetrators increased. On a similar note, Miller's secondary analysis (1984) of data from the 1st National Study of the Incidence and Severity of Child Abuse and Neglect (U.S. Department of Health and Human Services, 1981) found that adolescent mothers were more likely to be lone perpetrators while older mothers were more likely to co-perpetrate abuse with the child's father or father substitute. Miller's study, the only one to examine severity of abuse, found that the children of adolescent mothers were more likely to sustain fatal or life threatening injuries. This paper seeks not only to replicate existing results but also to expand knowledge by determining if adolescent and older mothers differ with regard to the prevalence and severity of nine neglect subtypes.

Methodology

Subjects. The 799 study families who met study criteria were selected to represent every family reported to the Baltimore City Department of Social Services for the first time during 1988.

Selection procedure. Development of the cohort of families involved two steps. First, we identified every family (n=2800) who (a) had been reported to the Baltimore City Department of Social Services for physical abuse and/or neglect during 1988 and (b) had been substantiated by the time we began the study sampling phase (January, 1989). Then from this group of 2800 families, we randomly selected 1675 families to screen for study eligibility. Inclusion criteria required that (1) the family live in Baltimore City at the time of the incident; (2) the biological mother be the primary caretaker of the child(ren) at the time of the incident; (3) the investigating caseworker confirm the presence of physical abuse or neglect; (4) abuse or neglect meet the minimum severity criteria for the study; and (5) this was the first confirmed report of abuse or neglect. To determine which families met these criteria trained research assistants read each family's child protective service case record. Of the 1675 selected cases, 799 met all five criteria.

Definitions of Physical Abuse and Neglect. We used "the combined approach," identified and described by Giovannoni (1989), to define physical abuse and neglect. Combined definitions included both an official designation (confirmation by child protective services) and an index developed by the investigator to "measure the specifics and severity of the maltreatment" type(s) (Giovannoni, 1989, p. 32). Families whose maltreatment was confirmed but did not meet the minimum severity standard were not eligible for the study.

The study's "specificity and severity criteria" were an adaptation of those developed by Magura and Moses (1986) and have been used by the second author in a number of previous studies (e.g., Zuravin, 1991.)

Child abuse. A physically abused child was defined as a victim of excessive and inappropriate use of physical force by a parent, parent substitute, or temporary caretaker who sustained an injury that met a minimum level of severity. Severity of injury was measured at the ordinal level and divided into four categories. For physical abuse to be considered present, at least one child in the family had to, at a minimum, meet the criteria for level 1. Level 1 included behaviors such as threatening with a gun, knife, or dangerous object, hitting with a fist, kicking, choking, beating up, smothering, etc. that increased the risk of a child for injury but did not result in injury. Levels 2, 3, and 4 included increasing severity of injuries.

Neglect. Child neglect referred to nine types of omissions in care on the part of the child's primary caretaker (the biological mother for this study) that resulted in, at minimum, a significant risk of harm. The subtypes were inadequate physical health care, mental health care, household sanitation, household safety, supervision, personal hygiene, temporary caretakers, nutrition, as well as instability of living arrangements. For neglect to be considered present, at least one child in the family had to meet the criteria for severity level 1 or level 2 for at least one of the nine subtypes. Level 1 meant that the child was at risk for negative consequences but at the point of the investigation was not showing any obvious signs of such consequences. Level 2 meant that the child suffered negative consequences.

Definition of adolescent mother. To determine if this study's findings were consistent with those of earlier investigators, we divided mothers into three age categories based on Bolton and colleagues' procedure (1980). Adolescent mothers included women who gave birth to their first child prior to 20 years of age and were less than 20 at the first substantiated report of physical abuse or neglect. Delayed adolescent mothers included women who gave birth to their first child prior to 20 but were 20 or older at the first substantiated report of maltreatment. Older mothers included women who were 20 or older at the birth of their first child.

Data collection methodology. Trained research assistants abstracted information on type and severity of maltreatment, physical abuse perpetrator, age of the mother at first birth and first substantiated report of maltreatment, and a variety of other parent and family characteristics from child protective service case records. Every case record was read and independently coded by two readers. Discrepancies between the two were resolved by a third reader, usually the project director. Research assistants were trained to 85% inter-rater reliability.

Findings

This section is organized into four parts: descriptive, type of maltreatment, physical abuse, and neglect findings. All analyses were conducted on 794 rather than 799 families because we were not able to identify the age at first birth for five of the mothers. Statistical procedures included Pearson's chi square and analysis of variance. When the overall chi square was significant, the crosstabulation table was partitioned into single degree of freedom subtables to identify differences among the three maternal age groups. When overall F statistic (anova) was significant, the Scheffe test was used to identify differences among the groups.

Descriptive information. The largest proportion of mothers were delayed adolescents (55.4%), followed by older mothers (32.6%), and adolescent mothers (12.5%). These findings differed significantly from those of Bolton and colleagues (1980) (older mothers = 54.9%, delayed adolescents = 24.5%, and adolescents = 6.9%). As expected and consistent with Bolton's findings, the three groups of mothers differed significantly with respect to age at first birth and first substantiated report. The average adolescent mother had her first child when she was 16 and her first substantiated report of maltreatment when her oldest child was 18 months old and she was 17.7 years of age. The average delayed adolescent had her first child at 17 and her first substantiated report of maltreatment about 10 years later when she was 27.7. The average older mother had her first child at 22.8 and her first substantiated report of maltreatment about 9 years later when she was 31.2.

As might be expected given what is known about the socioeconomic status of child protective service populations (American Humane Association, 1984) and the demographics of Baltimore City, the vast majority of families were African-American as well as very low-income. Overall, 83% of the mothers had ever received financial assistance from the Aid to Families of Dependent Children program (AFDC) and 90% were African-American. At the time of the report, 60% were AFDC recipients. Comparison of the three groups revealed that older mothers were significantly less likely that the other two groups to have ever received AFDC. Although the ethnic/racial composition of our sample differs from Bolton and colleagues (1980) (i.e., theirs was predominantly Anglo-American and included a substantial proportion of Hispanic-surname families), findings are similar. We, too, found that as maternal age at first birth increased the proportion of caucasian mothers increased.

Type of maltreatment. Consistent with data from national level studies (U.S. Department of Health and Human Services, 1988), neglect was more common than physical abuse (73.7% vs. 46.6%) for the study families as a group. However, the three previously cited studies (Bolton and Laner, 1981; Miller, 1984; Stier, et. al, 1993,) findings showed that neglect is more prevalent among the children of adolescent mothers while abuse is more common among the children of the two older groups. Similarly in this study, delayed adolescent and older mothers were somewhat more than twice as likely to have an abused child than adolescent mothers (50.2% and 49.8% vs. 21.1%) while adolescent mothers were approximately 37% more likely to have a neglected child (90.5% vs. 71.4%).

Physical abuse. Overall, moderate and serious injuries were relatively uncommon. Inspection of data on the most severely injured child reveals that the vast majority (75.4%) were either not injured at all or injured mildly. Consistent, however, with results from Miller's study (1984), this finding did not hold true for the abused children of adolescent mothers. They were more likely to suffer moderate and serious injuries. Compared to the children of delayed adolescents, and older mothers, those of adolescent mothers were almost twice as likely (35% vs. 18.1% and 22.4%) to have sustained moderate injuries and approximately 7 times more likely (20% vs. 3.6% and 2.3%) to have sustained a serious injury.

Overall, for 50% of the study families, the mother was the abuse perpetrator. Contrary to Bolton's and Laner's (1981) findings, however, our results did not show that adolescent mothers were more likely to perpetrate abuse than mothers from the two older groups. In fact, both the delayed adolescents and older mothers were somewhat more likely to be perpetrators than adolescents. Further, findings regarding male perpetrators did not support those of Bolton and Laner (1981). Father figures (fathers, stepfathers, and mother's boyfriend) were only somewhat more likely to abuse children of delayed adolescent and older mothers. While were unable to determine whether our sample mothers were sharing their household with a boyfriend or the children's father, it is possible that our findings differ from Bolton's because fewer of our delayed adolescent and older mothers shared their households with a male.

Even though the findings for mother and father figures do not reveal definitive differences, the category "unknown perpetrator" does. For 25% of the adolescent mother families compared to less than 5% of the delayed adolescent and older mother families, the investigating caseworker was unable to identify who perpetrated the maltreatment. Discussion with caseworkers revealed that adolescent mothers seemed much more reticent than older mothers to discuss the circumstances surrounding the abuse. Many of the caseworkers interpreted this reluctance as the mother's way of protecting not herself but the perpetrator. For many of these situations, the caseworker felt, but could not prove, that the mother's boyfriend abused the child.

Neglect. Of the nine neglect subtypes, the three most common were inadequate temporary caretakers, supervision, and physical health care. Caretaker neglect is the most prevalent, characteristic of 47% of the 585 neglectful families. Maltreated children from all three groups were equally likely to be victims of this type of neglect. On the other hand, the groups differed with respect to supervisory and physical health care neglect. Supportive of Miller's (1984) findings, physical health care neglect was more common among the children of adolescent mothers.

Of the remaining six subtypes, three --nutrition, personal hygiene, and mental health care neglect, were not equally common among the children of the three maternal age groups. Consistent with Miller's (1984) findings, nutrition neglect was twice as common among children of adolescents compared to those of older mothers. Similarly, personal hygiene neglect is significantly more common among the children of adolescent than older mothers. The total dependence of infants on their primary caretaker increases their risk for both of these forms of neglect. Not unexpectedly, mental health care neglect was significantly more common among the children of the two older groups of mothers.

Comparison by maternal age showed that the children of adolescent mothers were the victims of more neglect subtypes than the children of older mothers. And, as might be expected given the infant's vulnerability to ill-effects, the children of adolescent mothers are more likely than those of the two older groups to suffer severe consequences.

Discussion

Findings of this study of Baltimore, Maryland maltreating families generally support those from the three earlier efforts (Bolton and Laner, 1981; Miller, 1984; and Stier, et. al., 1993) despite differences with respect to ethnic/racial composition of the samples. Like the three earlier studies, this study found that neglect was significantly more common among the children of adolescent mothers. Similar to Bolton and Laner's (1981) findings, physical abuse was more common among the children of the two older groups. Consistent with Miller's (1984) findings, when the children of adolescents were abused, injuries were more likely to be severe. Also consistent with Miller's findings, the children of adolescents were more likely than those of the two older groups to be the victims of nutrition and physical health care neglect. Contradictory, however, to the results from the Bolton and Miller studies, our findings did not reveal that adolescent mothers were more likely than delayed adolescent or older mothers to perpetrate abuse nor did they reveal that males were more likely to be perpetrators for children of the two older groups of mothers. Findings add to knowledge in several ways. With respect to the most prevalent neglect subtype, inadequate use of temporary caretakers, the three groups did not differ. They did differ, however, with respect to five of the nine subtypes. The children of the two older groups of mothers were more likely to be victims of inadequate supervision and mental health care while those of adolescent mothers were more likely to be the victims of inadequate physical health care, personal hygiene, and nutrition. In addition, the children of adolescents were at higher risk for more subtypes of neglect as well as more serious ill-effects than those of delayed adolescents and older mothers.

Interpretation of findings and recommendations for future research. It is important to underscore that findings do not warrant conclusions about why there are differences in type and severity of maltreatment between the children of adolescent mothers and those of the two older groups. To determine whether differences reflect (1) the young mother's lack of specific parenting knowledge and skills, (2) her developmental level and its impact on her readiness to parent, (3) the heightened vulnerability of infants and toddlers to ill-effects and specific types of maltreatment, (4) characteristics of the baby such as low birth weight, prematurity, or pre-natal drug exposure or (5) some combination of the above reasons, more sophisticated studies are needed. Future research in this area should focus on addressing the above issues.

References

American Humane Association (1984). Trends in child abuse and neglect: A national perspective. Denver, CO: The American Humane Association.

Bolton, F. G., Jr., and Laner, R. H. (1981). Maturity and maltreatment. Journal of Family Issues, 2, 485-508.

Bolton, F. G., Jr., Laner, R. H., and Kane (1980). Child maltreatment risk among adolescent mothers: A study of reported cases. American Journal of Orthopsychiatry. 50, 489-503.

Elster, A., McAnarney, E., and Lamb, M. (1983). Parental behavior of adolescent mothers. Pediatrics, 71, 494-503.

Giovannoni, J. (1989). Definitional issues in child maltreatment In D. Cicchetti and V. Carlson (eds.), Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect (pp. 3-37). New York: Cambridge University Press.

Hayes, C. D. (ed.). (1987). Risking the future: Adolescent sexuality, pregnancy, and childbearing. Washington, D.C.: National Academy Press.

Magura S., and Moses, B. (1986). Outcome measures for child welfare services. New York: Child Welfare League of America.

Miller, S. (1984). The relationship between adolescent childbearing and child maltreatment. Child Welfare, 63, 553-557.

Stier, D. M., Leventhal, J. M. , Berg, A. T., Johnson, L., and Mezger, J. (1993). Are children born to young mothers at increased risk of child maltreatment? Pediatrics, 91, 642-648.

U.S. Department of Health and Human Services. (1981). National study of the incidence and severity of child abuse and neglect. Washington, D.C.: DHHS Publication No. (OHDS) 81-30325.

U.S. Department of Health and Human Services (1988). Study findings: Study of national incidence and prevalence of child abuse and neglect. Washington, D.C.: U.S. Department of Health and Human Services.

Zuravin, S. (1991). Research definitions for child physical abuse and neglect. In R. Starr, Jr., and D. Wolfe (eds.). Issues and research on child maltreatment. New York: Guilford Press.

Toward a Conceptual Clarification of Teen-Age Pregnancy: A Beginning Step for a Social Action Agency[1]

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This essay will reconceptualize and clarify existing phenomena known collectively as "the problem of teen-age pregnancy." It will primarily focus on selected terms, concepts and categories currently used to define and interpret the problem. Existing data and categories are subjected to analysis utilizing behavioral correlates, an approach offering greater insights into existing demographic data. By questioning the erroneous notion of "teen pregnancy" as an event and identifying it correctly as a process, a beginning step toward coordinating effective social action can be taken. A suggestion is advanced that we adopt a mandated post-natal visit to all new mothers, a system used for years in Europe, which could provide necessary information on the family type, resources, stability, and current attitudinal and behavioral data from teen mothers. From this profile would come a prioritized list of social, economic and health services most needed in the immediate future.

If the complex and delicate nexus of changing sexual values, gender equity issues, and welfare planning policies are more completely understood, a coordinated social action agenda is then possible with a multidimensional assault of preventative, interdictive and ameliorative programs designed to handle problems of adolescent pregnancy.

INTRODUCTION

Patterns of human behavior are expressed as concepts -- social labels -- which reflect the values and ideologies of the temporal era in which they were initially conceived. Closer examination reveals that although some concepts were thought to be definitive homogeneous entities, they are merely vague categories into which a collection of unrelated facts are dumped and retrieved as ad hoc interpretations of social phenomena, in this case teen pregnancy.

Normally, institutions in our society are effective only when they define their objectives precisely. But initial reactions can be deceiving. Take the example of our health care system. It deploys a two-tier system which maintains a vague category called illness for the public while simultaneously demanding more precise codes and classifications for use by its medical professionals. On any given day, hospital arrivals might include cases of trauma, the emotionally dysfunctional, those battling germs and infection, and females in labor. Each is diagnosed and handled at a separate station of the hospital. Treatment methods are prescribed by professional specialists who jealously guard their autonomy and monopoly of judgment as they proceed with diagnostics and treatment for these various maladies.

In most respects "teen-age pregnancy" (i.e. patterns of sexual behavior of the young) remains ill-defined not unlike the vague category of illness in medicine. However, unlike the hospital model, social action workers do not have the elaborate "second tier" of diagnostic/treatment specializations with the autonomy and control granted to health care professionals. Instead, social action workers must constantly fight for legitimacy as common sense non-sequitur explanations are offered by the mainstream public as popular cures for teen pregnancy.

The need for a fresh, new approach is obvious. This essay offers a new approach to teen-age pregnancy in linking behavioral correlates to current demographic data and by proposing a nationwide post-partum survey system as a continuous data source. If this pregnancy problem among the young is more accurately defined, greater coordination is possible among social programs directed at prevention, interdiction and amelioration.

TRADITIONAL CATEGORIES AND THE "PREGNANCY PROCESS"

Teen-age and Pregnancy as Deceptive Categories

Since the end of the World War II era, behavior circumscribed by the term "teen-age pregnancy" has expanded beyond the limits of the term itself. Technically, teen-age youth are of ages 13-19 years but an epidemic rise in childbearing among pre-teens is now occurring, including 10-12 year old mothers or even younger (Wright, 1989:6A). So a new concept-- **school-age pregnancy**-- is not only more accurate but a more meaningful social referent linking the disruption of public schooling with early motherhood.

Equally vague, and subject to popular interpretation, is the concept-- pregnancy. Although it can be defined accurately as a biological-genetic process commencing with fertilization, in social terms only vague numerical estimates of its presence exist-- derived from other vital statistics accummulated at a much later date. In fact, the sum of school-age miscarriages, school-age abortions and school-age live births equals the number of school-age pregnancies but in common usage, pregnancy and birth rates to adolescent mothers are mistakenly interchanged. If past trends hold, about 4-10 percent of all school-age pregnancies will end with miscarriages; another 40-45 percent will be terminated through induced abortion; and about 50 percent of them will survive as live births (Edelman, 1988; Iscoe, 1990).

Traditional demographic descriptions of school-age childbearing are inaccurate indicators of behavior. Changes which are ascribed to behavioral changes might well be caused by non-social factors. For example, a rise in "teen-age births" among mothers age 10-14 may be described as evidence of increased sexual promiscuity. While this behavioral factor should not be ruled out, this observed change could result from a numerical increase in females within that age category or conversely by a numerical decrease in the cohorts of older females. It might reflect behavioral changes toward more youthful "marriage" (including cohabitation) or a result of decreasing use of birth control devices. Court decisions rejecting legal abortions for the young could also have a direct effect on the rate of lives births among these very young mothers.

In sum, to be effective, programs to combat teen pregnancy must focus on changing attitudes and/or behavior, limiting their desire to speculate about meanings in demographic profiles. In cases where demographic-based speculations are the sole basis for action, that program will be ineffective. To enhance the scope and accuracy of attitudinal and behavioral data, a nationally-mandated post-partum visit is proposed as the most reliable mechanism by which to gather such information having to do with school-age mothers.

School-age Pregnancy as Process, not Event

Pregnancy is a complex process which can be arbitrarily segmented into three somewhat overlapping phases -- preventive, interdictive and ameliorative. These describe very different conditions of the school-age pregnancy process which call for an array of very different social action problems. Thus, groups with competing social action agenda must tolerate (not necessarily believe) dissimilar ideological objectives while expecting others to show similar restraints. This allows each to select that phase most receptive and compatible with its organizational ideals and objectives. As outlined in Figure 1 below, some action groups may focus on preventive aspects of initial pregnancy; others on interdictive methods; while others assist the new young mother and her child.

Figure 1

PROCESSUAL STAGES AND STRATEGIES TO REDUCE SCHOOL-AGE PREGNANCY

Prevention		Interdiction		Amelioration		
		(termination)			(retention/support)	
Virginity	Sexually Active	Miscarriage	Abortion	Adoption	Family	Public
Continued Abstinance	Sex Educ'n and Birth Control	-	Legal Abortion Clinics	Social Agencies Foster Parents	Parents or Self	Public Welfare Services

Source: From Stoddard (1993b: 86)

The prevention phase includes both abstinance and borderline interdictive measures. Abstinance involves early socialization toward deferred sexual gratification and personal responsibility. Socialization agents include family, religion and community, although similar themes underlying some secular programs are likewise effective in ameliorating this problem. But for preventive socialization to work, basic attitudes must be reinforced by social conformity including negative sanctions (i.e. social stigma) for non-compliance. Not only is this not happening, but a reverse trend toward increased laxity is occurring in contemporary society. As stated by one writer:

> There is virtually no widespread public sentiment for re-stigmatizing either of these classically disruptive behaviors [divorce, unmarried mothers] and no public consensus that they can or should be avoided in the future. On the contrary, the prevailing opinion is that we should accept the changes in family structure as inevitable and devise new forms of public and private support for single-parent families (Whitehead, 1993:52)

In the mid-1970s, three-fourths of all Americans said it was not morally wrong for a woman to have a child outside of marriage (Whitehead, 1993: 52). Also, non-conformity was euphemistically renamed "being sexually active" - a behavior beyond the reach of moral condemnation. Moreover, since most therapeutic programs to aid school-age mothers focus on mechanisms to allay guilt, these new ideologies have sustantially undermined social stigma. Thus, unless elements of traditional morality standards are reinstituted to guide youthful sexual conduct, youthful promiscuity will continue to flourish and the effectiveness of teaching abstinance will continue to decline.

As society accepts the "new morality" ideology, sexual activity among young girls accelerates. According to the Center for Disease Control, female "teens" reporting a minimum of one sexual experience increased from 38.6 to 52.5 percent between 1970 and 1988. In that same period, the rise in sexual activity among 15 year old females jumped from 4.7 to an alarming 25.6 percent. Inasmuch as early sexual activity directly increases the rate of school-age pregnancies and related problems over the years, the long-range impact of these changes in sexual activity have not yet become visible.

Some programs help younger girls to gain a greater sense of self-worth and become more self-reliant through long-range planning. Female alumni from these programs appear to be less vulnerable to the sexual pressures from adolescent males and respond with much lower pregnancy rates. One of these, the LAMP program in California, pioneered a "Big Sister" system for younger girls to assist them in their early development (Jackson, 1986:16). Similarly, the Mother-Daughter program in El Paso assigned "Big Sisters" as models and resources for "at risk" sixth grade girls but also included their own mothers in regular program participation. Its achievements are spectacular. Whereas in 1989-1991, 728 school-age pregnancies were reported in the three local school districts covered by the program, only three Mother-Daughter alumni became pregnant in the same period (Stoddard, 1993b: 88-90). This approach has merit and should be expanded throughout the country.

Probably the most frustrating aspect of preventative programs is the "tunnel vision" of social scientists and planners who direct their entire attention toward adolescent girls, ignoring the adolescent males whose "sexual conquest mentality" enters strongly into the numberr of youthful mothers (Dryfoos, 1988). Only fragmentary information on the role of male teens in school-age pregnancy is available but this shows that males must be targeted as well as females. Marsiglio (1987) found that 3-15 percent of teen males were willing to father a child out of wedlock, varying by socio-economic and racial categories. Finkel and Finkel (1984:443-446) reported that males were more informed about sexual reproduction than were females, but this knowledge had little to do with preferred or actual condom usage. Scott et al. (1988) found similar patterns among racial and ethnic minorities. If these are reliable guides to the sexual behavior of today's youth, the highly-rated medical-physiological approach to sex eduction (focusing on the process of reproduction) will do little to deter early sexual experimentation and school-age pregnancy (St. Pierre and St. Pierre, 1982:223-224).

Some critics of the "new morality" point out that while it liberates adults to pursue sexual activity free from constraint, at the same time it produces devastating consequences among the young. This "silent revolution" toward greater sexual promiscuity has elicited open criticism from European nations for promoting sexual irresponsibility among American youth. Although most European nations exhibit a much higher rate of pre-nuptual intercourse and cohabitation than the U.S., America has, by far, the highest teen pregnancy rates in the Western World and the highest abortion rate of all industrialized nations (Dryfoos and Bourque-Scholl, 1981; Jones et al., 1985; Mozny and Babusik, 1992).

One of the most popular approaches toward preventing school-age pregnancy involves interdiction-- an acceptance of the "sexually active" pattern among school-age youth while minimizing its impact. Within this approach, personal responsibility consists of efficacious use of hormones and/or birth control devices to restrict pregnancies which occur to those engaging in precocious sexual behavior. Recent campaigns to prevent the spread of AIDS through the use of condoms has been a "birth control" ally under the rubric of "safe sex."

One of the greatest moral dilemmas of our time involved the fight over legal abortion as an acceptable procedure for terminating an unwanted pregnancy. In 1972, Congress passed legislation intended to ensure racial equality in federal employment. Subsequently, this was applied to women in the military who had lost their careers for becoming pregnant. The courts assured servicewomen the right to occupational security which interpreted meant that they had a right to reproduction without incurring negative sanctions (York, 1978; Stoddard, 1993a). For women in the larger society, lawyer Sarah Weddington's classic case of *Roe v. Wade.* argued before the Supreme Court in 1973, established the legal right for women "to choose" the abortion alternative if they wished. These decisions are supported by many on the basis of the individual's right to choose,but most stop short of extending these to adolescent girls who might wish to obtain an abortion without parental knowledge or consent (Bonavoglia, 1988). This issue not only cuases disputes *between* gender, racial and socio-economic groups but internal conflict *within* them (Luker, 1984). Concurrently, fundamentalist self-proclaimed "true believers" (Hoffer, 1951) travel throughout the nation picketing abortion clinics, including their personnel and patients, in a zealous effort to save babies, those in "another woman's uterus." Even though about one-half of all school-age pregnancies now end by induced abortions, upon being made public, it once again becomes an explosive issue.

Currently, about ten percent of school-age pregnancies end in miscarriage. Inasmuch as the cause lies outside the control of the mother, no stigma results from such occurrences. But as the famous European abortion pill (RU-486) becomes legalized in this country, an abrupt rise in "private abortions" should be expected along with a sudden unexplained increase in the number of "miscarriages."

In the U.S., half of all school-age pregnancies ultimately result in live births. The state of Texas reports that two-thirds of its school-age pregnancies come to term, meaning that a corresponding drop in abortions also occurs. For ten percent of these babies, an adoption will be arranged. Not only does this uncomplicate the young mother's life but it allows childless couples to complete their family units. Economically, it favors the adolescent mother who is usually reimbursed her medical costs by the prospective new parents.

When school-age mothers decide to keep their babies, their choices of where to live are usually limited. They might depend on their extended family and friends for support or set up their own household. Whether this involves a male partner (cohabitation or married household) or the establishment of a separate single-parent domicile, most youthful mothers need and seek out agencies dispensing public and/or private assistance. Although the scientific literature describes how the family-of-origin is the main support of most new school-age mother, it may be a temporary or transitional form of help. When Garfinkel and McLanahan (1985) studied existing single-parent households, they found limited support from informal networks of extended family, friends and other singles. This form of assistance dwindles as single mothers move in search of better job opportunities and cheaper housing. O'Connell and Rogers (1984) found that only about one-half of these school-age mothers ever legally marry, and those who do wait an average of six years. Moreover, fifteen percent of these school-age mothers will bear an additional child before they leave their "teen" years (Ooms and Herendeen, 1989). Were the proposed national post-partum survey operating today, accurate information on these aspects of residence would be known.

School-age mothers, both those who share their parents' dwelling and those who establish a separate household, are mostly "school dropouts." One multiyear study in Chicago found that while only 10 percent of the non-pregnant teens left high school prior to graduation, 80 percent of the school-age mothers took that option (Hahn, 1989:259). An abrupt social isolation sets in as normal school routines and activities pass her by. Within the extended household, the additional expenditures for food, clothing, transportation and other necessities often create friction between parents and daughter; add to that the time and energy devoted to the offspring and a situation exists calling for the new mother to develop new coping skills (Dryfoos and Bourque-Scholl, 1981:84). The mother has a new status; the child often suffers her wrath arising from frustration.

For very young school-age mothers, special single-parent schools with modified curricula are usually available. Older teen-mothers either continue at these schools or try to become independent by seeking employment. But their search usually turns up some severe obstacles. First, the presence of a child involves endless responsibiities associated with child care; second, her formal education skills are usually below average unless she finishes her public schooling. Third, school-age mothers entering the job market find their job skills qualify them only for tedious tasks, entry-level unskilled positions, which pay only minimum wage and offer little advancement possibilities. Often they change jobs (and locations) in an effort to find better employment but find conditions similar everywhere. At this point they might hear of a social action program which will assist them to finish high school and/or increase their job skills. Without such opportunity, their discouraging employment experience will be repeated by their offspring who, as a rule, will be teen-age mothers and school drop-outs themselves (Greene, 1984; Furstenburg et al., 1987; Ortiz and Bassoff, 1987).

Public programs which provide support for school-age mothers to complete their education are less expensive than the costs of welfare, medicaid, law enforcement and the like. Yet, these will encounter the most taxpayer resistance. One El Paso program, Project Redirection, supported jointly by state agencies and local school districts. Its "case managers" operating out of the local YWCA, referral young mothers to the appropriate agency which could give them aid. The program's three long-range goals were narrowly defined and attainable: 1) to serve as an information and facilitation center for local social agencies which would meet the needs of school-age or post-school-age mothers; 2) to assist them to avoid further pregnancies; and 3) to help them finish high school and go on to further training whenever possible (PRSR, 1990; Wilson, 1991). Not only was it successful in human benefits, but it saved taxpayers about $1.50 in welfare entitlements for each $1 dollar spent.

In the U.S., never-married mothers of all ages require an ever increasing share of our welfare tax dollars. In 1986, this amounted to a hefty $18 billion dollars and constitutes the fastest growing item in the nation's budget. Rising costs are a product of increased number of clients rather than program expansion. Whereas in 1970, only 28 percent of never-married women sought AFDC payments, two decades later 54 percent were enrolled. In addition, these families remain on public assistance programs longer than others (Mayer, 1992:2). Conventional wisdom claims that welfare mothers are prolific so that they might increase their AFDC income. But recent research comparing welfare mothers to non-welfare mothers with similar characteristics reports lower rates for welfare mothers. Moreover, the longer they are on welfare, the less likely they are to bear a child (Rank, 1989). If this represents a rational decision to escape from welfare or results from age-related fecundity erosion is unknown. Equally unsettling is if these trends occur with never-married school-age mothers. Only with behavioral data from the proposed post-partum survey can these questions be answered.

A Call for a National Post-Partum Registration System

In most European countries, following the birth of a child, a home visit is made by designated authorities. America should initiate a similar system based upon the tested European model. Incorporated into the perfunctory visit could be questions relating to the family economic and social situation, explanations of personal values and behavior, and a more accurate profile of the nation's family types. If multiple tasks were accomplished in this interview which are currently duplicated in various agencies, the survey mechanism could be operated within current budget allocations. For example, in addition to gathering health and human resource datas, immunization schedules could be created and candidates for "special education" and handicap programs identified. The visit could include the paperwork upon which to issue a social security number. Comparing needs with current resources, those heavily utilized could be expanded; those under-utilized reduced accordingly.

President Clinton's current efforts to formalize a national health policy has focused on reallocating costs and funds to continue paying for specialized, hi-tech medical services which the medical establishment wishes to offer to the public. However, for an effective health care system to cover all Americans, it must begin with a Community-Oriented Health Care Model; simply stated, it determines what services are needed and then sets up programs to train people to furnish those services (Duarte, 1993). If the proposed post-partum survey were in place, it could furnish a continuous flow of data to help decision-makers to identify critical public services which are projected to be underused or overextended. Moreover it would shift our current orientation from corporate-provider interests to the needs of citizen consumers.

A BEHAVIORAL APPROACH TO SCHOOL-AGE PREGNANCY ISSUES

Teen pregnancy and teen parenthood problems begin with social values transferred from parents and others to the young through the socialization process. Personal attitudes are developed from these experiences which form the basis for subsequent actions. One program might target attitudes which would, in time, produce behavioral changes. Another might seek to change behavior directly. To do so, behavioral characteristics must be understood. It is important to know whether or not the pregnancy was unintended (accidental) or planned (on purpose). The stability or permanency of the family unit in which these babies will grow up is a critical factor. Intact vs disruptive families vary within as well as among various family types (i.e. legally married, divorced, cohabitating couples or single-parents). The simplistic labels of "married"/"unmarried" provide few clues to this motivational enigma. The utility of select behavioral dimensions becomes clearer with the following discussions.

Planned vs. unintended pregnancy. Unintended and intended pregnancies occur within both married and unmarried households. Even so, "unintended" has been mistakenly considered a synonym for the never-married category (Moore, 1988:4). "Unintended" can be linked with the ideology which separates sex as recreation from its procreative functions and considers pregnancy an accidental outcome. Thus, unless key elements of the "new morality" philosophy are discarded, little or no decrease can be expected in "unintended" school-age pregnancy rates. With regard to intended births, despite popular stereotypes to the contrary, a sizeable number of school-age mothers plan to have babies. Some of their reasons include the desire to have someone to love and care for, to qualify for welfare assistance, or to follow the popular single-parent female-only family model.

Kephart and Jedlicka (1991:230-231) describe the loneliness and isolation felt by some adolescent girls, a condition they refer to as status deprivation. Bearing a child fulfills that need to have an object of affection and someone to care for. Although the number of this type within the school-age pregnancy are unknown without having behavioral-attitude data available, they would be in the school-age birth column rather than teen pregnancies terminated by abortion.

A second reason given for school-age females who purposely plan a pregnancy is an economic strategy for financial security. In 1985, the U.S. spent $17 billion dollars for AFDC, Food Stamps and Medicaid to teenage mothers. Some experts claim that governmental policies guiding "transfer payments" or direct aid (AFDC) to poor families are strong incentives for poverty-prone girls, whether married or not, to bear children (See Easterlin, 1980; Jones et al., 1985; Ortiz and Bassoff, 1987; Cherlin, 1988). That mothers on welfare are less prolific than non-welfare females (Rank, 1989) might require re-analysis and reconciliation of these differing assertions.

A third explanation for school-age pregnancy concerns families fashioned after female-only single-parent models. A large number of established women feel that a female head-of-household family is a proper manifestation of feminist ideology. A symbolic indicator of female liberation is a home, children and career-- without a husband. The rapid growth in commercial "sperm banks" is one index of its popularity. School-age mothers would not initially plan this type of family but if they were raised in one, it becomes a viable option for them once they discover they are pregnant. The families described above may not suffer poverty but may be disruptive stress levels caused by overcommitment of time and energies. Such established middle-class families could explain some recent increased school-age pregnancy rates among white females (Kephart and Jedlicka (1991: 224)

Select single-parent type families are formed without strong ideological overtones, the involuntary casualties of cohabitation or divorce. These are disruptive. They, with school-age mothers, comprise the bulk of poverty families in the U.S. today (Stoddard and Hedderson, 1987:31-36). In addition, some widows may live in disruptive circumstances but others, through husband's estates, have become owners of the real wealth of America. Thus, this highly diverse category reflects diverse socio-economic and behavioral determinants.

Intact vs disruptive families. Many analysts erroneously substitute "married" for intact, "unmarried" for disruptive. But intact is not a synonym for any marital-legal category. This year, an equal number of children will live in single-parent households created by divorce (former intact?) as from school-age pregnancies. Cherlin mixes married and cohabitation families together in humorously suggesting that his forthcoming book on divorce/remarriage could have been titled--Cohabitation, Marriage, Divorce, More Cohabitation, and

Probably Remarriage. Canadian researchers record forty percent more reported abuse in step-family cases than those of traditional nuclear families (Whitehead, 1993:72). On the other hand, Burton's (1989) description of Black single-parent families reveals great stability resulting from intergenerational cooperation including child care by grandmothers. Likewise, some cohabitation families exhibit patterns of stability characteristic of intact families; some marry following the birth of children (Wiersma, 1983). Still, school-age mothers who marry because of the pregnancy continue to exhibit disruptive symptoms (Houghteling, 1990; 1993). It is evident that current demographic classifications do not explain disruptive family dynamics. But we do know that female adolescents from disruptive homes are sexually active earlier and more likely to become school-age mothers. They, in turn, model this pattern for their offspring.

Summary

As a beginning step to social action, this essay clarifies terms, concepts and dimensions of "teen-age pregnancy" in order to examine it within a behavioral framework. A proposed national post-partum survey system would furnish continuous attitude and behavioral data about school-age mothers upon which social programs might be effectively built. By conceptualizing school-age pregnancy as a process, rather than an event, a multidimensional assault of preventive, interdictive and ameliorative programs could be launched against it, phase by phase, according to the ideological perspective of each action entity involved.

ENDNOTE

1. Paper presented to National Association for Welfare Research and Statistics (August, 1993) Scottsdale, AZ.

REFERENCE BIBLIOGRAPHY

Burton, Linda. 1989. "Teenage Childbearing as an Alternative Life-Course Strategy in Multigeneration Black Families" Human Nature 1 (September):123-143.

Cherlin, Andrew. 1988. "The Weakening Link between Marriage and the Care of Children" Family Planning Perspectives 20(November/December):302-306.

Dryfoos, Joy. 1988. Putting the Boys in the Picture: A Review of Programs to Promote Sexual Responsibility in Young Males. Santa Cruz: Network Publications.

Dryfoos, Joy, and Nancy Bourque-Scholl. 1981. Fact Book on Teen-age Pregnancy. New York: Alan Guttmacher Institute.

Duarte, Pete T. 1993. Centro de Salud Familiar La Fe: From a Struggling Volunteerism to Regulated Bureaucracy. Unpublished M.A. Thesis, University of Texas at El Paso.

Easterlin, R. A. 1980. Birth and Fortune: The Impact of Numbers on Personal Welfare. New York: Basic Books.

Edelman, Marian W. 1988. Adolescent Pregnancy. Washington, D.C.: Childrens Defense Fund.

Finkel, M. L., and D. J. Finkel. 1978. "Male Adolescent Contraceptive Utilization" Adolescence 13:443-451.

Furstenburg, Frank Jr., J. Brooks-Gunn, and S. Philip Morgan. 1987. "Adolescent Mothers and their Children in Later Life" Family Planning Perspectives 19 (August):142-151.

Garfinkel, Irwin, and Sara McLanahan. 1986. Single Mothers and Their Children: A new American Dilemma. Washington, D.C.: The Urban Institute.

Greene, B. Z. 1984. Addressing Teenage Pregnancy and Parenthood. Washington, D.C.: Vocational School Boards Association, ERIC Clearinghouse.

Hahn, A. 1987. "Reaching Out to America's Dropouts:What to Do?" Phi Delta Kappan 69:256-263.

Hoffer, Eric. 1951. The True Believer. New York: Harper & Brothers.

Houghteling, Thomas W. 1993. Marital Decisions of Student Teen Mothers. Unpublished M.A. Thesis, University of Texas at El Paso.

Houghteling, Thomas W. 1990. Marital Decision-Making of the Pregnant Teen or Teen Parent. Unpublished Seminar Paper, Department of Sociology, University of Texas at El Paso.

Iscoe, Louise K. 1990. "Pregnancy and Parenthood" pp. 45-54 in Texas Teens--The Status of Adolescents. Austin: Hogg Foundation for Mental Health, Commission on the Mental Health of Adolescents and Young Adults.

Jackson, Ronald B. 1986. A Study of YWCA Services Performed for Pregnant and Parenting High School Students from El Paso from 1982-1985. El Paso: Schoolcraft Consultants (July).

Jones, Elise F., Jacquiline D. Forrest, Noreen Goldman, Stanley K. Henshaw, Richard Lincoln, Jeannie I. Rosoff, Charles F. Westoff and Deirdre Wulf. 1985. "Teenage Pregnancy in Developed Countries: Determinants and Policy Implication" Family Planning Perspectives 17 (March/April):53-63.

Kephart, William M., and Davor Jedlicka. 1991. The Family, Society, and the Individual (7th edition). New York: Harper Collins Publishers.

Luker, Kristin. 1984. Abortion and the Politics of Motherhood. Berkeley: University of California Press.

Marsiglio, William. 1987. "Adolescent Fathers in the United States: Their Initial Living Arrangements, Marital Experience and Educational Outcomes" Family Planning Perspectives 19 (November/December):240-251.

McManus, Mike. 1993. "Avoid a Bad Marriage by Learning about Your Steady Now" El Paso Times (March 12).

Meyer, Daniel R. 1992. "Paternity and Public Policy" Focus 14 (Summer):1-11.

Moore, Kristin A. 1988. Facts at a Glance-November, 1988. Washington, D.C.: Children's Defense Fund, Child Trends, Inc.

Mozny, Ivo, and Ladislav Rabusic. 1992. "Unmarried Cohabitation in Czechoslovakia" Czechoslovak Sociological Review 28 (August): 107-117.

O'Connell, Martin, and Carolyn C. Rogers. 1984. "Out of Wedlock Births, Premarital Pregnancies and Their Effect on Family Formation and Dissolution" Family Planning Perspectives 16 (July/August):157-162.

Ooms, Theodora, and Lisa Herendeen. 1989. Teen-age Parenthood, Poverty and Dependency: Do We know How to Help? Washington, D.C.: Coalition of Famiy Organizations, Family Impact Seminars.

Ortiz, Elizabeth T., and Betty Z. Bassoff. 1987. "Adolescent Welfare Mothers: Lost Optimism and Lowered Expectations" Social Casework 68 (September):400-405.

PRSR. 1990. Project Redirection Statistical Report: 1990. El Paso: Project Redirection, El Paso YWCA.

Rank, Mark. 1989. "Fertility Among Women on Welfare: Incidents and Determinants" American Sociological Review 54 (April):296-304.

Scott, C. S. L. Shifman, L. Orr, R. G. Owen and N. Fawcett. 1988. "Hispanic and Black American Adolescents' Beliefs relating to Sexuality and Contraception" Adolescence 23:667-687.

St. Pierre, Richard, and Tena St. Pierre. 1982. "Goals for the Overall Comprehensive Program" Health and Education 13 (May/June): 17-23

Stoddard, Ellwyn R. 1993a. "Female Particiption in the U.S. Military: Gender Trends by Branch, Rank and Racial Categories" Minerva: Quarterly Report on Women and the Military 9 (Spring):23-40.

Stoddard, Ellwyn R. 1993b. "Teen-Age Preegnancy in the Texas Borderlands" Journal of Borderlands Studies 8 (Fall):77-97.

Stoddard, Ellwyn R. and John Hedderson. 1987. Patterns of Poverty along the U.S. Mexico Border. Las Cruces: New Mexico State University, Joint Border Research Institute monograph.

Whitehead, Barbara Dafoe, 1993. "Dan Quayle Was Right" The Atlantic Monthly 271 (April):47-84.

Wiersma, G. E. 1983. Cohabitation, an Alternative to Marriage? Boston: Martins Nijhoff Publishers.

Wilson, Maria. 1991. Project Redirection: A Responsive Program for El Paso Teen-Age Mothers. Unpublished M.A. Thesis, University of Texas at El Paso.

Wright, Andrea. 1989. "Teen Pregnancy Rate Rises" Laredo Morning Times February 26:1A,6A.

Childhood Abuse, Teenage Pregnancy, and Welfare Dependency: Is There a Link?

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BACKGROUND: Most welfare policies that have been designed to help women leave public assistance in Washington and other states have focused on the education and work experience of participants. Evaluations of education and training-based welfare reforms have found that such approaches frequently increase earnings and reduce welfare use among participants, *but only by a modest amount* (Institute for Public Policy 1992). In order to improve the effectiveness of employment-based reform programs, it may be necessary to look at other factors beyond those traditionally considered to affect labor market success. This paper examines some of these other factors (specifically, childhood abuse as it relates to early sexual activity, dropping out of school, and teenage pregnancy and childbirth) and their link with later welfare dependency.

Previous Family Income Study research found that 52 percent of the women on public assistance in Washington State had been teenage mothers (Institute for Public Policy 1991). Having a first child while a teenager is associated with public assistance use, low educational attainment, and low hourly wages.

Recently, teenage pregnancy has been linked with a high prevalence of prior sexual victimization in Washington State, although no causal relationship was established (Boyer and Fine 1992, 11). In their study, Boyer and Fine found that two-thirds (66 percent) of the young women surveyed who became pregnant as teenagers had been sexually abused. This study was based on a sample of young women who were pregnant or parenting teenagers, and did not look at the incidence of public assistance dependency for these young women (age 21 or younger). The high rate of abuse found in this study prompted new questions, relating to sexual and physical abuse, to be asked during the Family Income Study's fifth year interviews of women on assistance in Washington.

INTRODUCTION:

This paper explores the following topics for women on public assistance:

- The prevalence of childhood sexual and physical abuse among respondents.
- The prevalence of childhood abuse in relation to early sexual activity, dropping out of school, teenage pregnancy, and teenage childbirth.
- The factors that increase the risk of early sexual activity, dropping out of school, teenage pregnancy, and teenage childbirth.

All findings in this paper pertain to abuse that women in the Family Income Study experienced ***while they were growing up***; a recent Washington State Institute for Public Policy issue brief offers findings on sexual and physical abuse that respondents experienced as adults (Institute for Public Policy 1993). Study data are based on telephone and face-to-face personal interviews. The Appendix includes the specific questions asked on physical and sexual abuse, and respondents' response rates; data are self-reported.

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THE PREVALENCE OF ABUSE

Childhood Sexual Abuse:

Family Income Study findings reveal that 38 percent of the women on public assistance in Washington State were sexually abused while growing up (compared to 30 percent for the at risk comparison sample*). This figure is higher than the proportion of abuse cases found in national studies of child sexual abuse: one national study (Finkelhor 1990, 21) found that 27 percent of the women surveyed reported sexual abuse while growing up (age 18 or under). This national survey's definition of sexual abuse was comparable to the Family Income Study's (see below) and included a wider range of behaviors: rape or attempted rape; unwanted touching, grabbing, or kissing in a public or private place; unwanted participation in nude photos, exhibitionism, oral sex or sodomy (Finkelhor 1990, 20).

For women on public assistance in Washington State, the median age of sexual abuse was 8 years *(half of those who were sexually abused were abused by the age of 8)*; the national median age of sexual abuse was found to be 9.6 years (Finkelhor 1990, 21).

Almost half (48 percent) of the women on assistance in Washington State who were sexually abused also reported physical abuse while growing up, compared to 31 percent for the at risk comparison sample.

> **Sexual abuse in the Family Income Study questionnaire was defined as: *unwanted touching, sexual assault, or rape* by a family member or others.**

Childhood Physical Abuse:

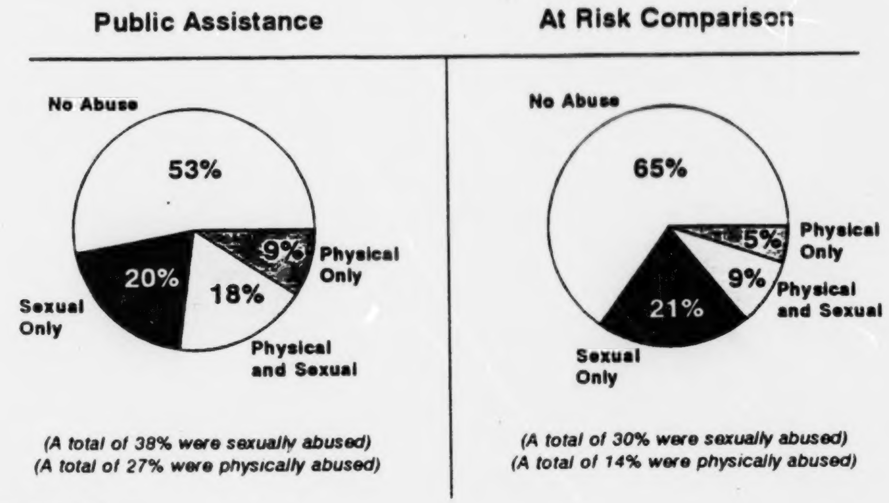
Physical abuse while growing up was reported less frequently than sexual abuse: 27 percent of the women on public assistance experienced childhood physical abuse (compared to 15 percent for the at risk comparison sample). The Boyer and Fine survey also asked questions concerning physical abuse: almost 64 percent of the young women in their survey reported they had been physically abused in one or more ways (Boyer and Fine 1992, 8). At present, there are no comparable figures on childhood physical abuse available from representative national data.

Two-thirds of the Family Income Study respondents who were abused physically were also abused sexually, in both the public assistance and at risk comparison samples (67 percent and 64 percent, respectively).

> **Physical abuse in the Family Income Study questionnaire was defined as: *being hit, kicked, punched, or beaten up, other than the occasional spanking,* by parents or guardians.**

The Family Income Study at risk sample is a comparison group of women drawn from neighborhoods that were more likely to have high rates of public assistance receipt.

More Women on Public Assistance Were Physically or Sexually Abused *While Growing Up*



(A total of 38% were sexually abused)
(A total of 27% were physically abused)

(A total of 30% were sexually abused)
(A total of 14% were physically abused)

Family Income Study
Washington State Institute
for Public Policy, October 1993

Discussion

A leading researcher on adolescent behavior reports that child sexual and physical abuse leads to early sexual activity, often without contraception, and teenage pregnancy (Dryfoos 1990, 104). Family Income Study findings reveal the following about women on public assistance:

RISK FACTOR	*Public Assistance*	*At Risk Comparison*
Engaged in early sexual activity *(before age 15)*	17%	9%
Dropped out of school	55%	24%
Were pregnant teenagers	70%	43%
Were teenage mothers	52%	25%

This section will explore the prevalence rates for each of the above four factors in relation to how many women were abused while growing up, followed by a list of all risk factors for each.

Early Sexual Activity: 17 percent of the women who were on public assistance in March 1988 began sexual activity *(defined in the questionnaire as "sexual intercourse")* before age 15, compared to 9 percent for the at risk comparison sample. The *median age* of first sexual activity was two years earlier (age 16) for the public assistance sample than for the at risk comparison sample (age 18).

> ***58 percent of the women on assistance who reported early sexual activity were sexually abused, and 42 percent were physically abused.*** Also, twice as many women who were sexually abused were sexually active before age 15 (26 percent compared to 12 percent for women who had not been sexually abused). Study findings suggest that child sexual abuse is linked to early sexual activity.

Dropping Out of School Before Graduating: 55 percent of the women on public assistance dropped out of school before graduating, compared to 24 percent for the at risk comparison sample. Study results show that 63 percent of the women on assistance who dropped out of school did so *before* their first pregnancy.

> ***41 percent of the women on assistance who dropped out of school were sexually abused and 30 percent were physically abused.*** The at risk comparison results were similar: 38 percent and 25 percent, respectively. These findings suggest that being abused as a child is linked to dropping out of school.

Teenage Pregnancy: 70 percent of the women on public assistance were pregnant teenagers, compared to 43 percent for the at risk comparison sample. *(NOTE: Not all pregnancies resulted in a live birth--women were asked to report whether their first pregnancy ended in a live birth, miscarriage, a still birth, or an abortion.)*

> ***42 percent of the women on assistance who were pregnant teenagers were sexually abused.*** Accordingly, 78 percent of those who reported sexual abuse while growing up became pregnant teenagers. Thus, findings indicate that sexual abuse is linked to becoming a pregnant teen.

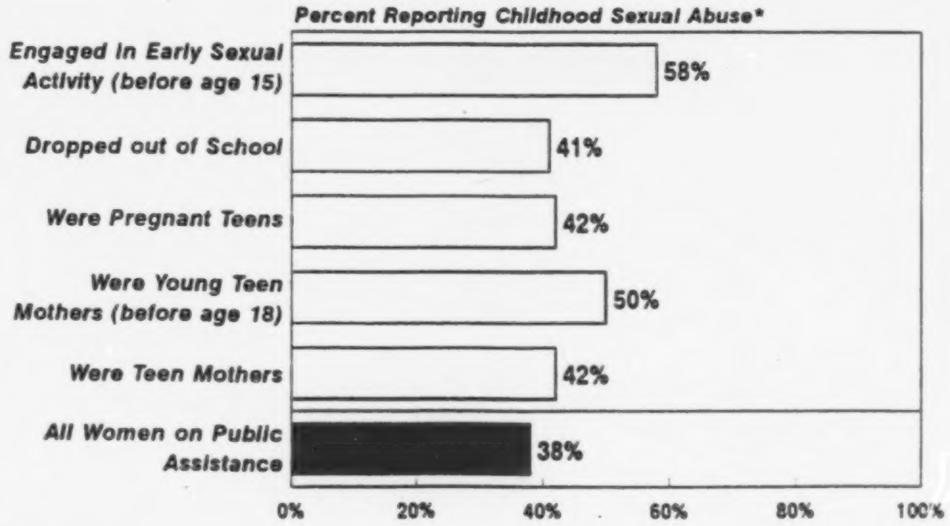
Teenage Mothers: 52 percent of the women on public assistance were teenage mothers, compared to 25 percent for the at risk comparison sample. Teenage mothers were more likely to: lack a high school diploma, go on public assistance, and earn lower wages than non-teenage mothers (Institute for Public Policy 1991).

> ***42 percent of the women on assistance who were teenage mothers were sexually abused. Women on assistance who were young teenage mothers (age 17 and under) reported an even higher rate of sexual abuse (50 percent).***

The following chart shows the prevalence of sexual abuse while growing up for women on public assistance in relation to each of the six factors listed below, including all women on assistance:

- 58 percent of the women who were *sexually active before age 15* were sexually abused.
- 41 percent of the women who *dropped out of school* were sexually abused.
- 42 percent of the women who were *pregnant teenagers* were sexually abused.
- 50 percent of the women who were *young teenage mothers* (before age 18) were sexually abused.
- 42 percent of the women who were *teenage mothers* were sexually abused.
- 38 percent of *all women on assistance* were sexually abused.

Childhood Sexual Abuse is Linked to Welfare Dependency Risk Factors



Family Income Study
Washington State Institute
for Public Policy, October 1993

* Sexual Abuse was defined as "unwanted touching, sexual assault, or rape" by a family member or others

The high prevalence of abuse in relation to early sexual activity, dropping out of school, teenage pregnancy, and teenage childbirth suggests a causal relationship and a pattern of behavior leading to welfare dependency.

Examining All Risk Factors:

The following section lists *all* factors that increase the risk of early sexual activity, dropping out of school, and teenage pregnancy and childbirth for women on public assistance in Washington State. The factors are ranked in order of their statistical significance and are measured by the size of their effect (see Appendix for more detailed description of methodology). This analysis confirms the prevalence of abuse, particularly sexual abuse, weaving throughout this pattern of behavior and the strong link between early sexual activity and dropping out of school with teenage pregnancy and childbirth.

Risk Factors for Early Sexual Activity (before age 15)

The following factors significantly contributed to the risk of early sexual activity:

- Younger than the Average Age of 12.5 Years at Onset of Menstruation
- Younger than the Average Age of 30 Years[*]
- Sexual Abuse While Growing Up
- Growing Up in a Single Parent Household
- Physical Abuse While Growing Up

Risk Factors for Dropping Out of School Before Graduating

The following factors significantly contributed to the risk of dropping out of school:

- Growing Up in a Household That Received Public Assistance
- Being Asian/Pacific Islander, Native American, or Hispanic
- Growing Up in a Single Parent Household
- Early Sexual Activity

Risk Factors for Teenage Pregnancy

The following factors significantly contributed to the risk of becoming a pregnant teen:

- Dropping Out Of School Before Graduating
- Younger than the Average Age of 30 Years
- Early Sexual Activity
- Sexual Abuse While Growing Up

Risk Factors for Teenage Childbirth

The following factors significantly contributed to the risk of becoming a teenage mother:

- Dropping Out of School Before Graduating
- Younger Than the Average Age of 30 Years
- Early Sexual Activity

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[*] The average age of women in the public assistance sample for the Study was 30 years in 1988.

CONCLUSIONS AND POLICY IMPLICATIONS

Women on public assistance who were sexually abused while growing up had an elevated risk of being sexually active at an early age, and were more likely to become pregnant teenagers and teenage mothers. Among public assistance women who were sexually abused, the median age of first abuse was 8 years.

91 percent of the women on assistance who were sexually abused and who were also sexually active before the age of 15 became pregnant teenagers. There is an equally strong link between early sexual activity and dropping out of school with teenage pregnancy: 71 percent of the women on assistance who were sexually active at an early age dropped out of school; of those who dropped out, almost all (93 percent) became pregnant teenagers. Half (52 percent) of the women on assistance were teenage mothers (Institute for Public Policy 1991).

Programs or policies that are able to prevent or mitigate the effects of childhood abuse may also reduce early sexual activity, dropping out of school, teenage pregnancy, and teenage childbirth, and later welfare dependency.

APPENDIX:

In order to explore the risk factors for early sexual activity, dropping out of school, teenage pregnancy and teenage childbirth, we examined those characteristics from the Family Income Study data that were present prior to the age of first sexual intercourse or becoming a teenager. This restricted the available data somewhat, but the questionnaire includes a number of the more relevant factors for this analysis. Since the median age of the respondents was 29 for the public assistance sample in the first year of the Family Income Study, recall error may be present in some of the variables used in this analysis.

The analysis of risk factors relied on logistic regression models to estimate the impacts of the various factors on the likelihood (or odds) of occurrence of the behavior of interest (e.g., early sexual activity). Only variables that are statistically significant at a 0.1 level or better are reported in this paper. The significant independent variables are listed in rank order of importance, measured by T ratios.

Complete regression results are available from the authors upon request.

Questions from the Family Income Study 1992 Questionnaire and Response Rates:

- *When you were growing up, were you ever physically abused by your parents or guardians (by this we mean: hit, kicked, punched, or beaten up), other than the occasional spanking?*

  (Valid responses were received from ***98.47 percent*** of the year 5 public assistance sample and ***98.96 percent*** of the year 5 at risk comparison sample.)

- *Again, when you were growing up, were you ever sexually abused (by this we mean: unwanted touching, sexual assault, or rape) by a family member or others?*

  (Valid responses were received from ***98.11 percent*** of the year 5 public assistance sample and ***98.43 percent*** of the year 5 at risk comparison sample.)

- *About how old were you when this first happened?*

  (Valid responses were received from ***96.49 percent*** of the year 5 public assistance sample and ***97.32 percent*** of the year 5 at risk comparison sample.)

REFERENCE LIST:

(Boyer and Fine 1992) Boyer, D. and D. Fine, "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives*, v. 24, 1992.

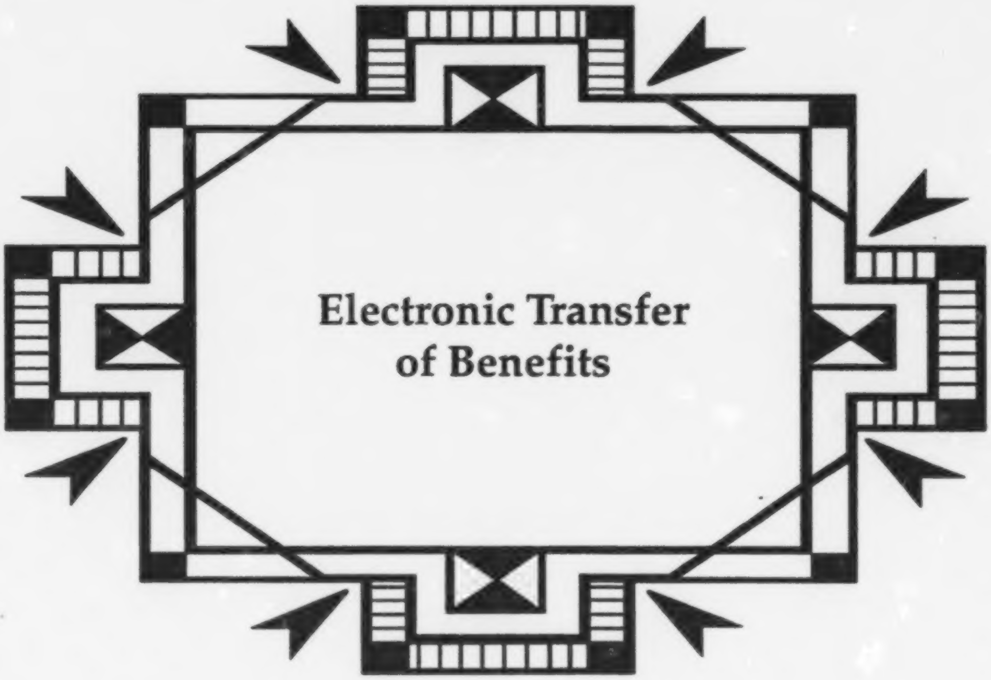
(Dryfoos 1990) Dryfoos, J., *Adolescents at Risk: Prevalence and Prevention,* New York: Oxford University Press, 1990.

(Finkelhor 1990) Finkelhor et al., "Sexual Abuse in a National Survey of Adult Men and Women: Prevalence, Characteristics, and Risk Factors," *Child Abuse & Neglect*, v. 14, 1990.

(Institute for Public Policy 1991) Webster, C. and F. Allesandro, *Teenage Mothers: A Life of Poverty and Welfare?*, Washington State Institute for Public Policy.

(Institute for Public Policy 1992) Washington State Institute for Public Policy, *Promoting Independence: Welfare Policy Options*, a conference summary, and *The Family Income Study: Recent Findings.*

(Institute for Public Policy 1993) Washington State Institute for Public Policy, *Over Half of the Women on Public Assistance in Washington State Reported Physical or Sexual Abuse of Women on Public Assistance*, issue brief.



Electronic Transfer of Benefits

Moderated by Edd G. Thigpen
South Carolina Department of Social Services

Win-Win, Electronic Benefit Transfer (EBT) and Health Passport: A Study of Feasibility and Application in Wyoming and Other Western States

Joseph S. Golden, Wyoming Department of Family Services

J. Terry Williams, Wyoming Women, Infants and Children (WIC) Program

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Win-Win, Electronic Benefit Transfer (EBT) and Health Passport: A Study of Feasibility and Application in Wyoming and Other Western States

Joseph S. Golden, Wyoming Department of Family Services, and Terrence J. Williams, Wyoming Women, Infants and Childrens (WIC) Program

Joseph S. Golden

Five years ago, a few of us in Wyoming State government became interested in the possibilities of Electronic Benefit Transfer or EBT. In 1987, I was asked to assume administrative responsibility for the Food Stamp program. I had one major question - can I get rid of those damnable food stamps and replace them with EBT. The Director at that time responded that she would prefer seeing them replaced with direct cash benefits or cashing out as that is called. I agreed but suggested that the political difficulties of cashing out were probably impossible to surmount and that EBT stood a better chance of succeeding. I still feel that way.

We would like to share with you our experiences over the last five years and some of the things we have learned - not just with an eye to the past but with an eye to the future. Specifically, we would like to tell you how our interest in EBT began, including a clear identification of the need and the dream; the steps that were taken to increase that interest and achieve consensus within our agencies; the need for inter-agency discussion and cooperation; the need for professional assistance in identifying baseline costs and alternatives; the need for recognizing some of the new actors that will be involved and the changing relationship of state government with those actors; and the need for clarifying the federal role in this area.

Our dream is to see a single state identification card that would be used for all state agency purposes - to see a card that could carry, or have access to, all basic needed information about that person. With our idea whatever agency the individual first comes into contact with would have responsibility for establishing the basic documentation for that person, including verification of that information. In most cases, this would be the Driver's Licensing Function. We ordinarily do not issue ID cards to children. Currently California, we understand, has moved to a system of digitalized pictures on an ID card with a magnetic stripe on the back carrying basic information, a card similar to the Mastercard you carry in your wallet except it has a picture on the front. The ID cards of the future will probably carry a hologram (or thumb print) for security purposes. This card could also have a small computer chip embedded into its surface and would thus be also be a Smartcard. It could also have an optical laser storage stripe.

This card could be used by all state agencies for identification, licensing, or benefit distribution purposes. The advantages of this sharing would be reduced costs, standardization of approach, reduction of duplication of effort in establishing and verifying identity and last but not least reduction of hassle to individuals applying for state services or benefits. Today, in most states if not all, persons applying to the local Job Service office have to establish whether or not they are aliens and have this verified through contact with the Immigration and Naturalization Service. If they apply for assistance with my agency, we have to verify their status also. How many times do we duplicate effort needlessly?

However, I am jumping ahead of myself. My first EBT thoughts were directed only toward food stamps. No one that I know of likes that funny money. The client is made to feel less than human when using them; the person next in line makes comments about welfare cadillacs and examines every item on the counter in a negative way; the checker has to remember all the rules about handling; the store manager has to physically count them; and I understand the bank weighs them. Separately from that, in Wyoming, a complete mail-issuance state, human beings have to sit around tables, checking and double checking each other, while they fill 12,000 envelopes with stamps every month. What a waste of time!

Some of this feeling must be shared by others because today there are at least 25 states at some stage of movement toward EBT. I have made available a list of all these states as of April of this year, from a U.S. Department of Treasury list (see pages 222-223). The state contacts listed are in the state welfare agencies.

As we started talking to other people in our agency about EBT, it became clear that there was a need for education. We arranged, in 1989, for Henry Dreifus, an expert in EBT and Smart Card technology, who was with Andersen Consulting at the time, to come to Wyoming to make a presentation regarding EBT. In deciding who to invite to this orientation, we decided to cast a fairly broad net. We asked representatives from any agency that we thought might have a possible use in this area - the list included, besides many representatives from my agency, Driver's License, Unemployment Insurance, State Auditor, Legislative Service Office, Workman's Compensation, and even Game and Fish. From that first meeting, it was decided to contact the Governor and ask him to establish an inter-agency coordinating committee to pursue the issue further.

Also, in the fall of 1989, Terry and I had the opportunity to talk to the Wyoming Grocer's Association. They were extremely receptive to the idea of moving toward EBT, recognizing the time and money savings that would be realized in the grocery stores. Not only would they not have to spend extra time on taking in the stamps, but the time-consuming chore of separate counting and reconciling of the food stamps prior to depositing would be eliminated.

One of the challenges we were given in moving toward EBT was that it had to be staff and cost neutral. Therefore, we needed to find out what our current costs were. This was not an easy task given that the current federal reporting system does not encourage accurate reporting of such information. In addition, we became aware that the project in Maryland was under significant scrutiny because of questions about baseline costs. This apparently led to some major problems with the federal agencies for a while.

STATE EBT ACTIVITY

Updated 02/23/93

STATE	*STATUS*	*PROGRAMS*	*CONTACT*
Maryland(2)	State-wide expansion continuing.	Bonus Child Support, Food Stamps, General Assistance, AFDC	Karen Walker
Minnesota Ramsey County Hennepin County	Operating EBT pilot. Preparing state-wide expansion.	AFDC(1), Food Stamps, General and Refugee Assistance	Margaret Philben Steve Gies Don Holmberg
New Mexico(2) Albuquerque	Operating EBT pilot.	Food Stamps, AFDC	John Waller
Pennsylvania(2) Reading	Pursuing addition of AFDC.	Food Stamps	Karen Van Bibber
Iowa(1)	In development phase for Food Stamps, operating AFDC.	AFDC, Food Stamps	Edith Pruismann
Wyoming	Developing an RFP for off-line system.	WIC, Food Stamps	Terry Williams
Ohio(2) Dayton	Operating Food Stamp offline-project. Preparing PAPD for addition of AFDC.	Food Stamps	David Schwartz
New York(3)	Electronic authorization to participate, but still issuing paper coupons and cash.	Food Stamps, AFDC	David Dobson
New Jersey	Vendor selected. Contract should be signed by February 1, 1993.	Food Stamps, AFDC	Patricia Cary
Texas	Submitted IAPD and RFP for Federal approval.	Food Stamps, AFDC	Isaac Jackson Penny Tisdale Robert Ambrosino
South Carolina	Vendor proposals received 1/25/93.	Food Stamps	Louis Wintzer Richard Swink
New Hampshire/ Maine/Vermont	Conditional approval PAPD. Feasibility study begun.	AFDC, Food Stamps General Assistance	Bob Pliskin Betsy Forrest
Missouri	PAPD approved by FNS and HCFA.	AFDC, Food Stamps, Medicaid, WIC	Jim Burns
Illinois	Contigent approval of PAPD by ACF and FNS.	AFDC, Food Stamps	Greg Wass
Oklahoma	RFP submitted for Federal approval.	Food Stamps	Dee Fones
California San Bernadino County San Diego County Los Angeles County	Revising FNS PAPD for Food Stamps. Proposed add EFT component. Revising PAPD for State.	AFDC, Food Stamps Food Stamp Cash Out demo AFDC, Food Stamps	Roberta Sellers Susan Gardner Lisa Nunez
Kansas	Contigent approval of PAPD by ACF , HCFA and FNS.	AFDC, Food Stamps, Medicaid	Gerry Schoenecker

STATE EBT ACTIVITY

Updated 02/23/93

STATE	*STATUS*	*PROGRAMS*	*CONTACT*
Florida	Submitted PAPD to ACF and FNS, FNS approval pending.	Food Stamps, AFDC, WIC	Lucy Hadi
Georgia	PAPD submitted to FNS and ACF.	Food Stamps, AFDC	Anne Howard
Massachusetts	Investigating EBT.	Food Stamps, AFDC	Richard Pedroli
Michigan	PAPD approved.	Food Stamps, WIC, AFDC	Dave Wigent
North Dakota/ South Dakota	PAPD approved by FNS and ACF.	Food Stamps, AFDC, Various state programs	Conrad Moe
North Carolina	Investigating EBT.	Food Stamps, AFDC, WIC	Albert Thompson John Freas
Oregon	Preparing PAPD.	Food Stamps, AFDC, State Assistance	Maurice Walker
Wisconsin	Investigating EBT.	AFDC, Food Stamps	Otto Young
Mississippi	Preparing PAPD.	Food Stamps	Robert Miller
Alabama	Preparing PAPD.	Food Stamps	Bill Mintz
Tennessee	Investigating EBT.	Food Stamps, AFDC	Kathleen Herak
Utah	Developing planning documentation.	Food Stamps, AFDC	Clyde Terry
Colorado	Investigating EBT.	AFDC, Food Stamps	Donald Bishop
Virginia	Investigating EBT, feasibility study completed. Awaiting state support decision.	AFDC, Food Stamps	Van Beggarly

(1) Operational, voluntary participation project.
(2) Operational, mandatory participation project.
(3) Electronic authorization only, no delivery of benefits.

PAPD - Planning Advanced Planning Document.
ACF - Administration for Children and Families
FNS - Food and Nutrition Service

Prepared by: The Financial Management Service, U.S. Department of the Treasury.

In order to overcome this lack of information, our agency decided, in the spring of 1990, to issue a Request for Proposal and to hire a consultant to help in establishing this baseline data. In addition, we asked for assistance in defining what approach should be followed by the state in the EBT arena. Should we go with magnetic stripe cards in what is called an on-line environment or should we go with Smart Cards in an off-line environment. On-line systems (magnetic stripe) process all the authorization and benefit transfer transactions on-line in real time against a central computer system. Off-line (Smart Card) systems have the ability to process transactions without accessing a central computer. All transactions entered in off-line systems must be recorded at the point of transaction and subsequently transmitted to the central computer for completion of processing. Both systems perform extensive batch processing in order to handle reimbursement of providers through EFT (Electronic Funds Transfer). The Smart Card stores benefit information that can be used to process transactions at the point of sale. The micro-processor on the Smart Card contains sufficient processing power to protect the integrity of the data on the card and to make it available, after suitable security checks, to a point of sale device.

The $140,000 that we spent on this effort was well spent. Most states, particularly smaller ones - and we qualify as the smallest in population - do not have the internal expertise to do this type of analysis. The recommendations were:

1) Although there are no financial benefits for the State of Wyoming to proceed today with EBT, the State should plan to implement EBT in the future when costs for hardware, software and telecommunications service may have decreased.

   Let me note here that there have been significant decreases in hardware and software costs which could make on-line distributed processing possible. This is particularly true, as you know, in the area of personal and mini computers, less so in the area of mainframe computers.

2) Evaluate the planned WIC off-line EBT pilot system to gain first hand experience with EBT transaction processing and off-line Smart Card based systems.

   During this study, the Women, Infant and Children (WIC) program started discussions with their federal regional representative about doing a pilot project in Casper.

3) Monitor on-line EBT ventures of other states.

4) After the WIC pilot evaluation (estimated to be late 1991 or early 1992), - If off-line processing was well received, (it was) and low priced ($500-$1000), highly functional Smart Card terminals are available, (they are) and - an off-line environment is cost-effective in comparison to an on-line environment, (it is) - **then** develop a statewide rollout plan with new off-line terminal technology and incorporate the Food Stamp and AFDC programs into the pilot. (we are currently

developing a multi-county roll-out and program expansion to Food Stamps as part of an Advanced Planning Document.) - **Otherwise**, standardize on on-line technology and develop an EBT strategy.

5) If EBT is chosen for Medicaid authorization, then develop a **separate** EBT strategy for Medicaid authorization since this program shares very few redemption centers with the other programs evaluated. The cost analysis shows that, in the current environment, an on-line EBT system would be far more cost effective than an off-line EBT system.

6) Begin to conceptualize the use of a single Smart Card in other capacities such as a driver's license and fishing license.

Andersen added that "Currently, the cost for EBT is high, but this should not keep Wyoming from progressing in the overall planning, evaluating and conceptualizing of an EBT environment."

In the fall of 1990, I had the opportunity to visit two EBT projects, Baltimore, Maryland and Reading, Pennsylvania. Reading is the oldest Food Stamp EBT project in the country. It began in October of 1984 and is a state operated on-line system. The system operates on a state mainframe computer.

The Reading pilot is an on-line application of EBT technology. Eligible clients are issued Magnetic Stripe Cards with their pictures on the cards for identification purposes. These cards are used by benefit recipients to purchase food at participating food stores. The recipient presents the EBT card to the cashier at the grocery check-out counter. The card is then passed through the store Point-Of-Sale (POS) terminal's card reader. The store terminal is connected via telephone communications to the mainframe computer where all Food Stamp benefit accounts are maintained. If the recipient's account has enough benefits to cover the intended purchase, the computer authorizes the purchase, debits the recipient's account, and credits the grocer's account. Receipts showing the purchase amount and the remaining balance are printed for the recipient and the retailer. Once a day, the EBT center totals each grocer's sales and initiates an electronic funds transfer to credit the grocer's bank account.

Baltimore, on the other hand, was one of the later projects, and was operated by a contractor. It too, however, was an on-line system. The major difference in the Baltimore project was the addition of cash benefits. At first, these benefits were only paid out through bank ATM machines. However, later grocery stores were able to issue cash to the clients. This was encouraged in order to avoid the ATM fees. I would offer the following suggestions and/or comments based upon my review of those two projects:

o Working directly with the grocery stores is a whole new area for the state food stamp agency. In Reading's case this required a significant staff commitment from the agency for the answering of questions from the stores on a daily, if not hourly, basis. This could potentially raise criticisms from the stores regarding the number of different state agencies working with the stores - i.e. the public assistance agency, the state Department of Agriculture, the health department (state and/or local).

- In Reading I found equipment on the store counters that had been placed there at the beginning of the project - it was old, it was large - this was a sore point with the grocers - counter space is at a premium, it is money. However, they did not want to replace it themselves, with their money - that was a state responsibility.

  Quandary - if the state places the equipment at state/federal expense, it has to be maintained and upgraded. Given state financial problems, is this realistic? Major consideration needs to be given to who is responsible for purchasing and maintaining. Political pressures will be placed by the stores, and their associations, for states to place, maintain, and upgrade and/or pay a processing fee **despite the fact** that stores will see a significant decrease in expenditures when they do not have to process food stamps. It should be noted that while I was in Reading the state was discussing upgrading the equipment. Another thought here is that given the rapid changes in technology, if the state has to pay, leasing may be a better option.

- A separate, but related issue, is the responsibility of the state versus the responsibility of the Food Stamp Program of the Food and Nutrition Service. FNS has always maintained that it is their responsibility to work with the stores, to approve stores for accepting food stamps, for giving counseling to the stores on the redemption of such food stamps and also for guiding/reprimanding stores for improper acceptance or usage of food stamps. On the one-hand FNS sees it as a state responsibility to work with the stores in the area of EBT but at the same time at least one federal representative has indicated that they do not see any diminution of their responsibility in this area - Do I sense some power games and staff protection? On the other hand, what are the implications for the states, staffing and otherwise, if FNS turns that area of responsibility over to the states? In Wyoming, at least, we have begun discussions with our Department of Agriculture in this area. I personally would prefer a system which keeps our agency, the welfare agency, as far away as possible from the stores.

- Contractor versus state operation. My observation of the two projects combined with other considerations is that contractor operation, whether through a bank or other private contractor, is the better option. State governments, whether considering their welfare agencies or central data processing operations, can neither afford the staff or expertise to manage this type of project directly.

o Training of staff and clients was an area stressed in both projects and of significant importance during our WIC Smart Card pilot.

J. Terry Williams

My story today is to detail for you first, our initial smartcard feasibility study as applied to WIC, second, to present the multi-program WIC/Food Stamp project we are about to launch, and third, to represent Tom Singer, the Western Governors Association, Director of Research in describing the multi-state health passport project that is under development, which was initiated by our Governor Mike Sullivan.

Among the greatest utilities of EBT and smartcards is that they present government with the opportunity be creative in implementing an electronic systems solution in the delivery of government programs. As Joe inferred from the Anderson study, linkage among clients receiving Federal and State human services is very high. For example, Anderson identified that 79% of Wyoming Food Stamp clients participated in one of more of the other three programs studied; i.e., WIC, and/or AFDC and/or Medicaid. For WIC, 46% of our clients also receive Food Stamp benefits. As management, why should we continue to pay $2 per month to deliver paper WIC benefits per family unit, while Food Stamps spends $4 per month to deliver coupons when half the WIC clients live at the same address and a smartcard that costs $10 could be used to deliver both programs but has a half life of three years? (In France, I recently visited a French Health Maintenance Organization that was using a card that was designed and programmed by the manufacturer to routinely manage seven different services, and with compression techniques could be easily adjusted to handle several more.)

Second, the information needed for certification/ authorization across health and human service programs to both facilitate the delivery of service and payment of services is amazingly uniform. Robin Rather, the futurist daughter of Dan Rather, suggests that perhaps 85% of the information needed across services is common. Why not empower our clients by allowing them to carry it in some kind of secure, portable electronic media, like a smart card to by which they can only authorize access to selected providers when it is appropriate? If you are carrying the composite information with you on a smart card, which is fully interactive with local, unlinked equipment, its also comforting to know that "big brother" only has the information in bits and pieces, versus comprehensively stored on a mainframe. Before proceeding with my WIC story, let me distribute two sample smart cards. The first WYO card is what we used to manage the food prescription for the WIC feasibility study. The second card is a sample DoD card that is currently being piloted in Hawaii with 300,000 troops and military dependents. This multimedia card is being used for health, food services, personnel and finance. I'm particularly interested in the DoD project because through WGA we'd like to see inter-operability between our state cards and the DoD card for health services and benefit programs like WIC and Food Stamps.

I'm getting somewhat ahead of myself. First the WIC feasibility study and the findings. We were drawn to using smart cards in our frontier environment because of the high costs of long-distance telecommunications and small program numbers. Even though our WIC service is fully distributive as contrasted to centralized Food Stamp distribution you still have to collect certain information and make timely payments to the participating retailers. The information you collect is critical. For WIC, as a supplemental food prescription, we are concerned that the moms and kids get the specific foods that will be the most good in improving their birth outcomes, and resolving pre-existing health and nutrition problems. This smartcard system enabled us to have the client shop by according to the Universal Product Codes that are contained on every food product. UPC codes also allowed us to electronically track every can of infant formula purchased by WIC participants. For WIC this is important, as Congress has mandated, each State to establish competitive bids to secure rebates. Rebates for Wyoming represent over $1 million dollars annually, and allow us to serve an additional 1600 moms and kids. Nationwide, over $800 million is earned enabling service to 20 to 25 of the National caseload.

I also want to acknowledge and support Joe's thesis, that whatever system you select, on-line or off-line; smart cards, optical laser cards or magnetic stripe cards; plan to have the system developed and operated through the private sector. Whatever mode you select, you will be tying into capacity of the existing commercial infrastructure, which can function far more efficiently than we can as individual states. Vice President Gore talks about these electronic highways that Federal and State governments should be using. Perhaps we need to be recommending enabling legislation to encourage this window of opportunity.

A comprehensive user evaluation of the study was completed by Alan Moore, Ph.D. of the University of Wyoming. Some of the significant findings included:

- 800 WIC mothers and children shopping at four retail stores in Natrona County, Wyoming, used Smart Cards to manage their benefits. While one-third of the participants are "unbanked" and never owned a credit card, they unanimously preferred managing benefits using a Smart Card.

- Clients found the card faster and easier to use. They better managed the WIC Program benefits. Participating merchants experienced savings in reduced banking costs associated with the alternative paper check system. Store staff were relieved of having the responsibility of being the "police person" because WIC shopping was controlled by Universal Product Codes (UPC). In some cases merchants were paid more promptly through use of electronic banking.

- Local WIC staff prefer Smart Cards to checks because family distribution is quicker and benefits can be "remotely replenished" in an emergency. State management staff prefer Smart Cards because of higher system integrity, and infant formula rebates are increased because of system accuracy.

- Smart Cards can be a win-win-win solution for clients, private sector businesses and state agencies.

The major card handling differences between the Casper project and the Reading project are:

- WIC is a distributive, PC-based system.
- WIC utilizes the Uniform Product Code (UPC) as determining factor in storing data on the card on eligible products.
- Processing of benefits is conducted at the POS terminal. The information that the store needs to determine benefits is stored on the card itself within the memory chip. The reader/printer on the cashier's counter is able to determine the benefits available and debit the card.
- A personal computer in the store is used to collect and store information from each of the check-out lanes.
- The stores are polled once a day by modem and the information is collected and stored on a personal computer. This results in low dependence on telecommunications services, therefore lower telecommunications cost. This system does not utilize the state mainframe computer thus resulting in significant savings.
- The information is then taken to the bank by computer disk where the information then generates electronic deposits to the merchant's accounts through the existing automated clearinghouse system.

As a result of our initial efforts we received some welcome publicity: It didn't hurt to have Catherine Bertini go shopping with several WIC moms the day the system went live. Second, the international smartcard industry annually polls all its members and votes on the outstanding card application. We won that distinction in 1992. I mention our three main competitors only to show you the diversity of smart card uses: The Toshiba smart card application to their Japan world headquarters; a Guatemalan bank using smartcards where there is less than 11 phones per 100 citizens; and the Government of South Africa to record the unique wave variations of each gold Krugerrand, to guarantee authenticity. Third, our Department Director also encouraged us to enter the annual Ford Foundation, Harvard School of Government "Innovations in State and Local Government" Competition. With over 1600 entries, we made it to the 25 national finalist. By being written up in "Governing," we have received over 100 inquiries for additional information. By passing the monetary award onto WGA, we've used it to gain the critical mass necessary to proceed with the feasibility study and system design of the Health Passport project.

- The linkage that exists among use of benefit programs also exists among health services. Why not use an already valued card to facilitate access and management of health services?

- The Smart Card can be used as a secure medical record for the individual or family to eliminate redundant applications and eligibility determinations - 89% of the information needed is "common." As a portable health record, the card will contain the most current essential information and link health providers.
- Equipment in each provider office will only allow for access to information needed for that particular service, i.e., immunization record; prenatal care; family planning, etc.
- Cards can bridge public and private health care and facilitate a health management information system data base to measure progress toward statewide health goals.
- A multi-state WIC/Health Passport system is being considered for future sharing between Oregon, Idaho, Montana, North Dakota and Wyoming.

Next, I'd like to share with you our plans for proceeding with an integrated WIC/FS system solution. This pilot will be the first national electronic combining of WIC and Food Stamps. USDA is highly interested in comprehensively evaluating this initiative. To that end, they are getting ready to release an independent evaluation contract that may end costing 2/3 to 3/4 of our total project. We are moving forward on this project because we have the support of the food retailer community. Without their agreement to participate, we'd really be dead in the water. The process of developing this retail relationship, through the earlier feasibility study was challenging. I thought we were on the right track by originally involving the local store managers in our initial planning retreats. I soon learned, however, that the needs of local store management in serving the customer are complementary to corporate office philosophy, but express themselves in different priorities. Corporate offices have ten year plans and it's important to know how your state EBT interests can be integrated with corporate. Corporate also looks at everything from the perspective of market share and the competition. This translates into issues of how long will an EBT point-of-sale transaction for WIC or FS take, as compared to the existing paper systems. They know, within milliseconds, how long a FS transaction takes. Unionized personnel represent their major non-food operating costs. They are also highly concerned with who owns the float and how quickly will they get paid. Retailer involvement in planning, contracting, system design, functionality and acceptance testing are critical. Most larger retailers are represented by the Food Marketing Institute. This organization develops the industry position papers and represents retailers before Congress and the Administration.

It's also significant to note that, if one piece of equipment can be used for multiple applications such as debit, credit, WIC, Food Stamps, and check writing; everyone can potentially be miles ahead.

Our combined pilot will involve 2,100 Food Stamp households who shop at 51 food retailers in Natrona County and 5,000 WIC participants who shop at 39 retailers in the seven county area of southeastern Wyoming. 1,700 of these WIC participants live in Natrona and so, where appropriate, will use their cards for both programs. Households will be able to shop as often as they wish. Past studies indicate Food Stamp households shop an average of 10 times per month, while WIC clients shop an average of four. Food Stamp clients will probably elect to have their benefits electronically loaded onto their cards at the first POS transaction of the month. WIC clients will return to the clinic every other month to have benefits refreshed, receive nutrition counselling and have health checks. The system will also provide for a WIC remote replenishment feature, so that benefits can automatically be renewed under certain emergency conditions. This feature is most welcome in Wyoming's winters when snow and wind periodically forces us to cancel remote clinics because of road closures and related emergencies.

We expect clients using both programs to find it more convenient and efficient to manage their combined food resources using one electronic card. If paper instruments are lost in both programs, they are not replaced. Using an electronic card, the balance of the remaining benefits can be restored in 24 hours. Food Stamp emergency issuance can be expedited. A household can be authorized on Friday afternoon at 4:45, issued a card, and have benefits loaded for use the first thing on Saturday morning. For exceptional conditions, if/when the electronic system is down, a manual back-up paper system is usually in place.

Retailers should benefit because of increased retail sales, reduced POS transaction times, less "cashier/police person" work, and less management time spent in processing paper instruments and reduced or eliminated bank charges. State and local field staff should gain through the ability of providing more efficient service, less time spent investigating mail fraud and stolen benefits and as appropriate, replacing benefits. In a state like Wyoming, the approximately $20,000 per month spent in assembling and distributing the paper Food Stamp instruments would be saved. For WIC staff, we expect improved ability to manage food resources, by tracking food expenses by UPC codes, increased rebates by better documentation of purchases, less clinic time spent issuing benefits by cards vs. checks, improved counselling ability on the use of the food prescription, and improved ability to provide complete family food management counselling for those families participating in both programs. In summary, we expect both the WIC and Food Stamp programs to be enabled to better fulfill there independent and complementary goals and objectives.

There are additional actors in the EBT process besides the state and the food retailers. EBT functions through a processor who downloads benefits to clients and polls the retail stores to obtain the transaction information. This processor may also be the concentrator bank, who reviews and summarizes data by retailer, by program and facilities daily electronic payment to the participating retailers. The processor also has to provide daily reconciliation to the state by program, based on what benefits where authorized and downloaded. The processor is also usually involved in client and retailer training, trouble-shooting, supply and equipment servicing. Other players are also involved in the system including the Federal Reserve, Treasury, Smartlinks, etc.

In this pilot, several WIC issues, including technology issues need to be solved. They include WIC Program integration so a single POS scan can used for both the retailer and WIC program; UPC control at the retail store PC level, with the state office being able to adjust the approved list on a daily basis; and ideally, client service in all lanes.

I want to acknowledge a large USDA Food Stamp smartcard project that is currently being completed is the Dayton, Ohio, project. The project is being managed by Dave Swartz of the Ohio Department of Human Services in Columbus. Dave could give you good insight from his extensive experience. This project is being evaluated by Phoenix Technology of Rockville, Maryland. Gary Glickman of Phoenix is the principle investigator. National Processing Company of Louisville is the contractor. Sid Price is the Senior Vice-President.

I have several outstanding EBT concerns: 1) USDA regulatory definition of cost neutrality is quite restrictive; 2) EBT and card technology standards are still in a developmental stage; 3) Many express concern as to the outcome of the final rule by the Treasury on state liability and processing standards when cards are reported as lost or stolen; 4) In cash programs such as AFDC, how many times should a client be able to use an ATM machine before having to pay a service charge?; 5) What can be done to maintain the intent and individual program objectives, while removing artificial barriers to electronic program application? and; 6) In an EBT environment the State and Federal Food stamp responsibilities change. Should the State/Federal relationship and funding formula not reflect the new program management responsibilities?

In addition to using the card to carry WIC and Food Stamp benefits, the WIC staff through this pilot plans to gain additional experience in using the card as a portable program data base. Nationally, a Verification of Certification (VOC) card exists in the WIC program. This card enables the WIC client transferring from one project to another within a state or across state lines, to maintain participation and program benefits during the valid certification period. The card, unfortunately, doesn't contain much information, and so frequently services are started over upon reaching the new state. A portable electronic data file would be much more complete. In addition to WIC information, we also expect to carry the immunization record for each family member. It is estimated that up to 50% of children at age two are under-immunized. Linking WIC childhood data bases with immunization and EPSDT services makes sense. In Wyoming, the Health Check, our Medicaid EPSDT program, is currently reaching less than 20% of eligibles.

For further information or for a full copy of the report, please contact the authors (see address list).

Homelessness

Moderated by Deanna Seabridge
New York Department of Social Services

Evaluating the Effectiveness of Using Intensive Case Management and Indepent Housing to Stabilize the Chronically Mentally Ill Homeless - Richard Hough, Ph.D., San Diego State and University of California

Preventing Homelessness: An Empirical Report of Why Shelter Services Don't Work - Larry W. Kreuger, M.S.W., Ph.D., University of Missouri, John L. Stretch, M.S.W., Ph.D., St. Louis University, and Michael J. Kelly, M.S.W., Ph.D., University of Missouri

Patterns of Residential Instability: Some Early Findings from the Evaluation of the Homeless Families Program - Debra J. Rog, Ph.D., C. Scott Holupka, and Kimberly McCombs, Vanderbilt Institute for Public Policy Studies

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Evaluating the Effectiveness of Using Intensive Case Management and Indpendent Housing to Stabilize the Chronically Mentally Ill Homeless

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BACKGROUND

In 1987, the Stewart B. McKinney Homeless Assistance Act (Public Law 100-77) established a dmonstration program for homeless persons with severe mental illness. Administered by the National Institute of Mental Health Offce ofPrograms for the Mentally Ill, this program funded nine project serving homeless menally ill adults. In 1990, under a second round of McKinney funding, NIMH and, later, the Center for Mental Health Services, SAMSA, awarded an additional six dmonstration projects focused on services for severely mentally ill adults. These grants were an outgrowth of a Memorandum of Understanding between the Departments of Health and Human Services and Housing and Urban Development.

The San Diego project, "Client Focused Housing Support Services for the Homeless" was one of the second round sites. The San Diego project initially involved close public/acadmic liaison between San Diego County Mental Health Services, San Diego County Mental Health Services, San Ysidro Downtown Mental Health Center, Episcopal Community Services, the San Diego Housing Commission and the Housing Authority of San Diego County. Its purpose was to evaluate the effectiveness of providing comprehensive supportive services coordinated with independent housing alternatives for severely and persistently mentally ill homeless persons.

The project employs an experimental design, with randomized assignment to experimental and comparison groups. Homeless mentally ill persons (N=362) who met project criteria have been assigned to one of four conditions: (1) comprehensive case management (CCM) and housing; (2) traditional case management (TRDCM) and housing; (3) CCM and no housing; and (4) TRDCM and no housing.

By the end of current NIMH funding, the project will have collected baseline and six month followup interviews over a full three years. The case management interventions will close out at the end of 30 months, so participants in the experiment will have been followed for six months post-project. Monthly case manager reports and case file abstraction data will have been collected on all respondents for at least twelve months.

The primary research hypothesis is that the combination of comprehensive and flexible supportive services with permanent housing will produce better client outcomes including: a) level of severity of psychopathology; b) increased stability of housing; c) improved functional status; d) improved quality of life and life satisfaction; e) improved physical health condition; and f) more effective use of mental health services. More specifically, researchers hypothesize that comprehensive support services and housing will each produce better outcomes than the comparison condition of traditional homeless case management. The design allows testing for the additive effects of the two experimental conditions and for interactive effects as well.

The proposed project also intends to evaluate the effects of a "step down" of service level for those originally assigned to the CCM conditions (i and 3). Little is known concerning whether original gains achieved in CCM are maintained when the level of support is decreased or removed. When clients in those two conditions finish eighteen months of intensive case management, they are being randomly assigned to (a) a continuation of the original intensive case management for another 12 months or (b) a transitional case management condition which closely resembles traditional homeless case management. The same outcomes as above will be tracked.

Service Provision

The major differences between the two levels of case management are summarized in Figure B. TRDCM was provided by San Diego County Mental Health Services (SDMHS) and CCM was provided by "Team Elan", a program developed by Behavioral Health Group at their Downtown Mental Health Center under contract from SDMHS.

Figure B. Service Component Comparisons

Variable	CCM	TRADCM
1. Caseload Size	22 Maximum	40 Maximum
2. Team Approach	Yes	No
3. Client Access to Services	7 Days 24 Hours	5 Days 8 Hours
4. Intake	Immediate	7-14 Days
5. Housing Support Groups	Yes	No
6. Salary	$32,000	$27,000
7. Specialized Training	Yes	No
8. Service Brokering Funds	Yes	No
9. Supported Employment	Yes	No

A section 8 housing certificate from either the San Diego City Housing Commission or the Housing Authority of the County of San Diego was available to all clients in conditions 1 and 2 who chose to complete the application process and who met the criteria of the housing authorities.

Recruitment into the Project

Some 466 homeless mentally ill individuals referred from the community and San Diego Mental health Services have been screened to locate 362 eligibles for the project. Not all homeless mentally ill persons were eligible for participation in this project. Eligibility requirements were greatly affected by the fact that case management services were being provided through SDMHS and that housing certificates were being provided through the two local housing authorities. All three of these public service organizations operate under certain local, state, and/or national regulations defining their scope of responsibility and the clientele they are to serve. For SDMHS, for example, persons with primary diagnoses of substance abuse are, by state policy, to be served by county alcohol and drug treatment programs and persons who are on probation must have their public mental health services provided by the state probation system. The two housing authorities have regulations designed to protect the rental housing in which their clients are placed and to protect the neighbors of clients. For example, the client cannot be of danger to himself or others, and must have a source of income (usually an entitlement program) which will allow him/her to pay 30 percent of the rental. All three agencies worked closely together in this project to modify their eligibility criteria as far as possible to accommodate the special characteristics of the seriously mentally ill homeless population. The resulting eligibility criteria are summarized in Figure C.

b. Subject Referral and Screening. Some 466 potential subjects were referred to the project. Referral points included homeless outreach teams, emergency psychiatric units, case management services, outpatient programs, socialization centers, day treatment centers, regional outpatient clinics and crisis residential centers. Clients referred from programs which had no internal diagnostic procedure (e.g., shelters) were referred first to the county homeless outreach teams who reviewed the severity of their mental health problems and appropriateness for the project.

Figure C. San Diego McKinney Homeless Demonstration Grant Eligibility Criteria.

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1. Persistent, primary major mental disorder, in a non-acute phase at time of referral. (Usually operationalized as a current DSM-III-R diagnosis of Schizophrenic, Bipolar or Major Depressive Disorder on the Diagnostic Interview Schedule (DIS). In the absence of a DIS based diagnosis, a few clients with incontrovertible evidence of diagnosis were admitted.)
2. Not a danger to self or others. (E.g., not in need of crisis intervention. Client is past any crisis phase and no serious homicidal or suicidal ideation or threat are evident.)
3. Has not been arrested for the manufacture or sale of illegal drugs.
4. If has a recent history of illegal drug use, is actively committed to a drug-free lifestyle and is working toward recovery.
5. Has not been arrested for any felonious violent criminal activity that has as one of it elements the use of force.
6. Is homeless - undomiciled and does not reside at a fixed address designed for or ordinarily used as a regular place of residence.
7. If in a public or private shelter or transitional program, has lived consecutively in such accommodations 45 days or less, by time of referral.
8. Able to live independently, with supports.
9. Eligible por potentially eligible for some income which would allow the individual to maintain an apartment.
10. Owes no money to a public housing authority.
11. Willing to participate in the research and accept case management services for at least 12 months.

Clients could be screened from program admission at three stages (Figure E). First, personnel in referral source organizations had to make the decision that a client was appropriate for the program. Although referral sources were not asked to keep records of how many of their clients they screened out as inappropriate for the program, a survey was conducted of major referral sources at the completion of baseline. Subjects were asked, of the homeless, mentally ill clients they saw during the previous year and did not refer, what proportion were excluded because they did not meet each of the eligibility criteria. Most of those excluded were serious drug users with no serious intent to quit their habit, had mental disorders other than schizophrenia, major depression or bipolar disorder, were regarded as incapable of independent living or did not meet the project homeless criteria. Some 9 percent of those who were asked if they wanted to enter the project refused the offer.

A second screening process occurred when the referral source phoned the research office to arrange for a baseline interview and project eligibility criteria were formally reviewed. As a result of discussion and/or a research request for further information, it was sometimes found that the client had a serious drug abuse problem, an inappropriate mental disorder, did not meet homeless criteria or had a history of arrest for violent crime. A final screening occurred when the subject finished the baseline interview. Not many clients were screened out at this point, but several did admit they had histories of arrest for violent crime, and some were either unable to complete the interview or were found not to have an appropriate mental disorder.

Characteristics of Clients.

The baseline characteristics of the 362 clients admitted to the project included the following. Approximately two-thirds were male, most were white and most were between 19 and 44 years of age. Total income averaged about $350 a month. Only 10 percent of the clients reported no income, and only 13 percent reported any earned income. The other 77 percent reported some entitlement income of some sort. The modal years of education was 12. Approximately one third had been homeless less than one year, one third 1-3 years and one third 4 years or more. The great majority had been homeless more than once, and over half had been homeless five times or more. Some 55 percent received a diagnosis of schizophrenia and 45 percent major depression. Only 12 percent reported current substance abuse, but approximately 50 percent reported diagnosable level abuse at some point in their lives. All but 13 percent had been admitted to a hospital or treatment facility for mental health problems at some point in their lives.

Preliminary Outcome Data

1) Case Management Activity - CCM and TRADCM conditions have been analyzed across the first six months of the project. CCM case managers have roughly twice the contact with their clients and traditional case managers in the first two months of the project. By the sixth month, however, the differences in amount of case management contacts does not appear to be significant. In terms what kinds of client needs are focused on by the two programs, the differences are not as dramatic as might be expected. The CCM team has apparently concentrated slightly more of its resources on living problems of the client, particularly in the first two months, and on vocational issues throughout the first six months. The TRADCM team apparently concentrated somewhat more on economic issues of its clients. There were no significant differences between the case management conditions in the proportion of client contacts concentrated on mental health, physical health, or social needs, nor on substance abuse problems.

In terms of who originated case manager contacts (clients, case managers or third parties), the results suggest that CCM case managers are much more likely to report client originated contacts than traditional case managers. Apparently, CCM case managers are more likely to appear approachable and available to clients than traditional case managers.

Housing condition also affects the amount of case management contacts. This is particularly true for case management contacts having to do with living arrangements and substance abuse needs. Case management condition differences were more conetrated on vocational and mental health needs in addition to living arrangements.

2) Housing - In the two housing conditions of the study, approximately 60 percent are currently living in their own house or apartment. Only 1 percent are still on the streets, although some 8 percent are in temporary housing (including shelters, hospitals, recovery homes, crisis centers or jails) and some 15 percent are currently missing. We estimate that approximately half of those may be homeless again.

CCM has only been marginally better than TCM in the total number of clients who are currently in independent housing. CCM initially placed significantly more clients in housing and more quickly than TCM. However, more CCM clients have dropped out of independent housing (some 15 percent of those housed).

It should be noted, however, that clients in the housing conditions are doing much better than those in the non-housing condition where only 34 percent are living in a house or apartment. Approximately 1 percent are homeless and 25 percent are missing to case management and may be homeless. Another 8 percent are in temporary housing. Again, CCM is only marginally more effective in getting clients for whom a section 8 certificate was not reserved, into housing.

Some preliminary analyses have been conducted of whether there are recognizable differences between clients who enter housing and those who have not entered or who have dropped out. To date, no dramatic differences have been observed. In terms of demographics, those dropping out and not getting into housing are more likely to be male and to have slightly higher education, although the differences are slight. Interestingly, those quitting their section 8 housing appear to have a higher mean monthly income. Homeless history variables do not seem to be associated with housing status. A diagnosis of schizophrenia or bipolar disorder may be mildly associated with quitting or not entering housing.

Reasons for quitting housing once it has been received have also be examined. Although, the data is very preliminary, twelve clients have abandoned their housing, all of them CCM clients. Of the remaining CCM clients who are no longer in their housing, only 5 were evicted, 2 are in jail, 2 moved to non-Section 8 housing and 1 is looking for a different apartment. For TRDCM, only 9 clients have moved out of Section 8 housing, of whom 4 were evicted, 3 were voluntary, 1 is in jail, and 1 is searching for alternative Section 8 housing.

3) Other Outcomes - The table below presents preliminary six month follow-up outcomes by baseline, case management condition and housing condition. The only outcome variables on which case management condition has an effect at six months are income and case management satisfaction. Clients in CCM score significantly better on both. No case management effects were found on quality of life, symptoms of mental disorder or hospital use. However, clients in Section 8 housing exhibited significantly greater satisfaction with quality of life, were somewhat likely to exhibit lower CES-D and CSI depression scale scores, and were more satisfied with case management. It should be noted, however, that improvements in quality of life and symptom scores were found in the 263 subjects as a whole. Satisfaction with living arrangements and safety improved from approximately 3.5 to 4.5, and with life as a whole from 3.2 to 4.3. Similarly, CES-D scores improved from a very high level (32.1) to a somewhat more moderate 26.8, while CSI depression scores dropped by about 2.5 points and CSI schizophrenia scores by about a point.

Table 7. Six Month Follow-Up Outcomes by Baseline, Case Management Condition and Housing Condition.

	Housing by Case Management Effects				Housing Only		CCM Only		ANCOVA F Test p <				
Sect. 8	N	N	Y	Y	N	Y			BASE LINE	CCM EFFECT	SECT 8 EFFECT	INTER-ACTION	NUMB. SUBS.
CCM	N	Y	N	Y			N	Y					
Quality of Life													
Life as a whole	4.0	3.9	4.3	4.1	4.0	4.2	4.1	4.0	.000	.555	.177	.582	263
Social Relationships	4.3	4.2	4.3	4.5	4.2	4.4	4.3	4.3	.000	.701	.093	.648	262
Living Arrangement	4.2	4.3	5.0	5.2	4.3	5.1	4.6	4.7	.012	.604	.000	.495	261
Neighborhood	4.5	4.4	4.9	4.9	4.4	4.9	4.7	4.6	.000	.526	.033	.485	261
Safety	4.4	4.2	4.7	4.7	4.3	4.7	4.6	4.4	.000	.536	.019	.412	263
Symptoms among Schizophrenics*													
DIS Schiz. score	1.6	1.8	1.9	1.9	1.7	1.9	1.8	1.8	.000	.672	.355	.871	143
CSI Schiz. score	11.4	11.4	12.8	12.8	11.4	12.8	12.1	12.1	.000	.690	.103	.764	143
Symptoms among Major Depressives*													
CES-D score	32.4	28.6	26.8	26.6	30.7	26.7	29.4	27.6	.001	.242	.098	.835	79
CSI Depr. score	23.8	23.2	19.7	21.1	23.6	20.3	21.6	22.1	.001	.652	.036	.973	80
DIS Depr. score	4.9	4.4	4.3	5.2	4.7	4.7	4.6	4.8	.012	.925	.835	.466	80
Symptoms among Bipolars*													
CES-D score	32.1	23.2	21.2	23.2	27.2	21.8	25.6	23.2	.027	.363	.063	.628	36
CSI Depr. score	26.6	18.8	19.2	22.0	22.3	20.1	22.2	20.0	.060	.197	.128	.032	36
DIS Depr. score	4.5	3.4	3.6	3.0	3.9	3.4	3.9	3.2	.583	.417	.499	.965	36
DIS Mania score	2.9	0.9	2.7	2.3	1.8	2.6	2.8	1.4	.291	.061	.484	.256	36
Hospital Use													
# Inpatient adms.	0.5	0.5	0.4	0.6	0.5	0.5	0.4	0.6	.000	.346	.918	.541	236
Number days inpatient	2.1	1.4	0.9	3.2	1.8	2.0	1.5	2.3	.000	.390	.886	.020	252
Income													
All income last month	532	604	520	583	569	551	526	593	.000	.032	.491	.751	253
Case Mngt. Satisfaction													
General satisfaction	4.1	4.7	4.5	5.2	4.4	4.8	4.3	4.9		.000	.009	.705	254
Satisfaction w/CM help		4.1	4.3	4.5	5.0	4.2	4.8	4.3	4.7		.019	.001	.453 52

*Outcomes on measures of schizophrenia are analyzed for clients entering baseline with a diagnosis of schizophrenia. Similarly, depression measure outcomes are analyzed for persons entering the project with diagnoses of major depression. For persons entering the project with bipolar diagnoses, depression and mania measures are examined.

DIS schizophrenic scores = count of number of 4 schizophrenia criteria symptom groups (delusions, bizarre delusions, hallucinations and prominent hallucinations) for which the respondent scored positively on the Diagnostic Interview Schedule.

CSI Schizophrenia score = total on five schizophrenic symptoms in the Colorado Symptom Index scored from 1-5 in terms of their frequency of occurrence.

CES-D score = total on twenty items in the Center for Epidemiologic Studies Depression Scale scored from 1-5 in terms of their frequency of occurrence.

CSI Depression score = total on seven depressive items in the Colorado Symptoms Index scored 1-5 in terms of frequency of occurrence.
DIS Depression score = count of the number of 9 depression criteria symptom groups for which respondent scored positively on the Diagnostic Interview Schedule.
DIS Mania score = count of the number of 6 mania criteria symptom groups for which the respondent scored positively on the Diagnostic Interview Schedule.

4) Followup Data

To date, we have been able to complete 93 percent of our six month, 87 percent of the 12 month and 85 percent of the 18 month followups. Preliminary analyses have been completed on the first 263 clients to complete six month follow-up interviews, 89 percent of the eligibles. The suggest that respondents who are missing or who refuse do not differ drastically from respondents on whom interviews have been completed. They are much less likely to have been in San Diego County the full twelve months before the baseline interview and somewhat more likely to be male.

Conclusion

To date, we have been very pleased with our ability to conduct an experimental evaluation of the effectiveness of case management and Section 8 Certificates as a means of stabilizing the chronically mentally ill homeless. Preliminary data suggests that, given housing and case management support, stabilization is possible for some 70 percent of clients who have entered the housing condition segments of the program. The benefits of comprehensive case management have been negligible to this date, but it should be noted that many analysts suggest that case management loads have to be reduced to no more than ten to obtain the benefits of a comprehensive program. Our comprehensive case management loads averaged 25.

PREVENTING HOMELESSNESS: AN EMPIRICAL STUDY OF WHY SHELTER SERVICES DON'T WORK

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Michael J. Kelly, PH.D.

Background

Over the last 15 years in St. Louis there has been an increasingly significant investment in poor families who have suffered from the uprootedness and attendant crisis of homelessness. These economically troubled homeless families have differentially benefited from concerted casemanagement efforts by a network of public and private agencies to deal with their many crises; stabilize them; place them as functioning families in the community; and support their rerooting by a community networked process of case management and follow-up. Until recently, there were no systematic data which charted the outcomes and impacts of casemanaged community networked resources. Management had no efficient way to assess the impact of programs aimed at helping the homeless while they resided in shelters nor to monitor the continual functioning of formerly homeless families in the community after their initial homeless crises had been resolved.

The authors were engaged in designing and implementing two computer assisted homeless-serving projects in St. Louis which were directed toward gathering management oriented outcome data. After briefly reviewing two computer-assisted homeless shelter management projects the authors discuss empirical findings on the value of such services compared to housing-based subsidies and the reasons for downsizing shelter-based services. Finally developed is a rationale for a critical assessment of shelter approaches to larger policy requirements of the homeless.

The Rationale for Shelter-Based Services

A review of the literature and experiences of the authors in over 10 years of study of homeless families finds the following general reasons for shelter-based services:

Reasons for Shelter-Based Services

1. Shelter-based nightly quarters are preferable to sleeping in harsh conditions under bridges or in cardboard houses. (Bidinnotto, 1991)

2. Shelters provide emergency living quarters on a temporary substitute basis for low income often minority families who cannot afford other living arrangements and who suffer from random and unpredictable natural events such as fires and disasters or from largely unpredictable political or economic events such as foreclosures, evictions, condemnations. (Karger and Stoez, 1990)

3. Shelters provide short term solutions to immediate survival needs for food, clothing and bedding for people who have lost their place of residence (Kreuger, 1987).

4. Shelters offer some protection for potential victims of crimes of street violence such as rape or drive by shooting and other environmental trauma, (Institute of Medicine, 1988)

5. Shelters offer security as stopping off havens for low income persons passing through and transients who would otherwise be sleeping on park benches. (Wright, 1989)

6. Shelters provide safe destinations for abused women and abused or neglected adolescents who are contemplating seeking help. (Institute of Medicine, 1988)

7. Shelters sometimes offer an mechanism for getting better housing through placements, subsidies, vouchers. (Stretch and Kreuger, 1990).

8. Shelters offer minimal last line of defense against harsh economic and political reality of mean spirited politicians whose economic policies cause gentrification and the subsequent loss of low income housing, and the various economies of greed. (Karger and Stoez, 1990)

9. Shelters provide collateral support for law enforcement officers who are able to drop off intoxicated persons who need a place to sleep it off rather than using inappropriate hospital or jail space (Blau, 1992)

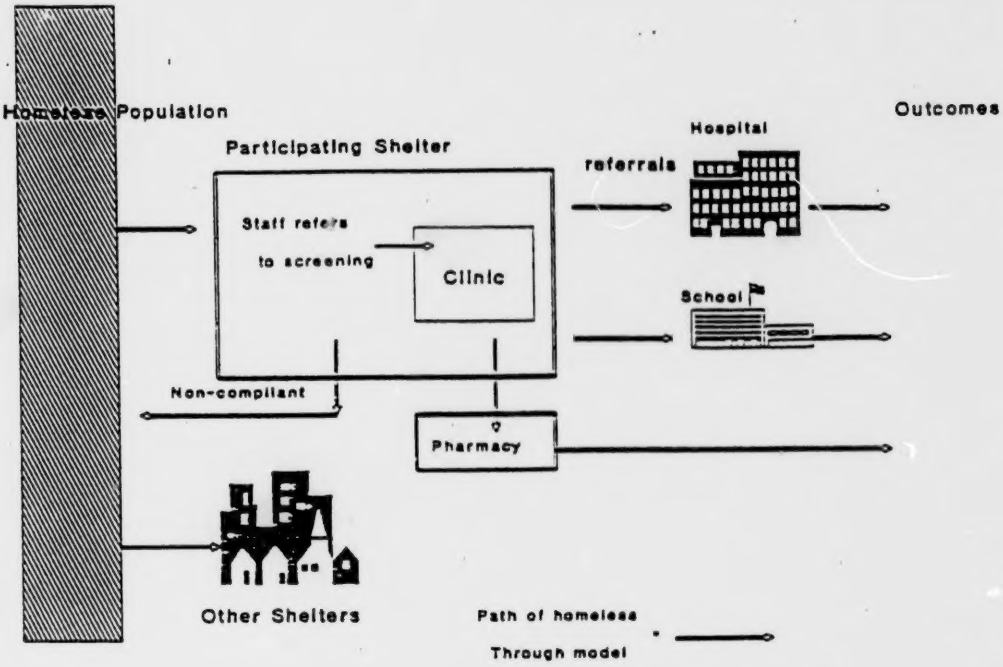
10. Shelters offer last line of defense for persons of color who have been systematically discriminated against the search for apartment rentals, those discriminated against in mortgage and home repair loans, and redlining by banks (Blau, 1992)

Two Computer Assisted Management-Evaluation Projects

Model #1: Health Care for the Homeless Coalition of Greater St. Louis

Health Care for the Homeless program provides a special set of services to homeless families and children. There are several points in the health and social services delivery model of the St. Louis project which are the focus of tracking. Tracking procedures are defined here as the operationalization of computer-assisted information gathering protocols useful for both policy and program evaluation, and for more global management purposes. The assessment of effective and efficient care requires that program managers be provided with quasi-longitudinal data. There are several focal points or nodes where health and follow up outcomes have been operationally defined as shown in Figure 1.

FIGURE 1. Health Care for the Homeless Coalition Model


Homeless Population
Participating Shelter
Staff refers
to screening
Clinic
Non-compliant
Pharmacy
referrals
Hospital
School
Outcomes
Other Shelters
Path of homeless
Through model

There were three major points where tracking data were significant. First, medical screenings provided one opportunity for rather simple counts of the number of shelter residents who were referred to the screening team by shelter staff, compared to the number of homeless who actually attended screening sessions.

Referrals which the primary screening physician made to hospitals, neighborhood clinics, and social agencies provided another source of tracking data. It was critically important for the medical director and advisory committees to be able to assess whether homeless persons keep appointments, follow medication regimens, and otherwise attend to recommended services.

It was important to assess the effectiveness of interventions for homeless persons for purposes of justifying fund raising efforts. For example, one of the goals of the St. Louis Coalition was to determine if the homeless partake of health and related services without further intervention. That is, would those persons who desired to remain homeless, or those who had not yet solved their problems, regularly use health care services should the Coalition cease to provide the continuing care?

The problem of noncompliance among homeless persons was a vital area for the development of tracking data. The measurement of compliance presented major methodological difficulties in the delivery of traditional health and related care. With regard to homeless populations, non-compliance was of special significance not only because it directly related to successful outcomes, but also because it was very difficult to measure in unanchored, homeless individuals. Some homeless persons may be considered as generally non-compliant with the norms and expectations of the community at large. Their lifestyles often run counter to community standards, and their preference for isolated street life makes noncompliance take on a normative, rather than a deviant, character.

How Management Utilized HCHC Data

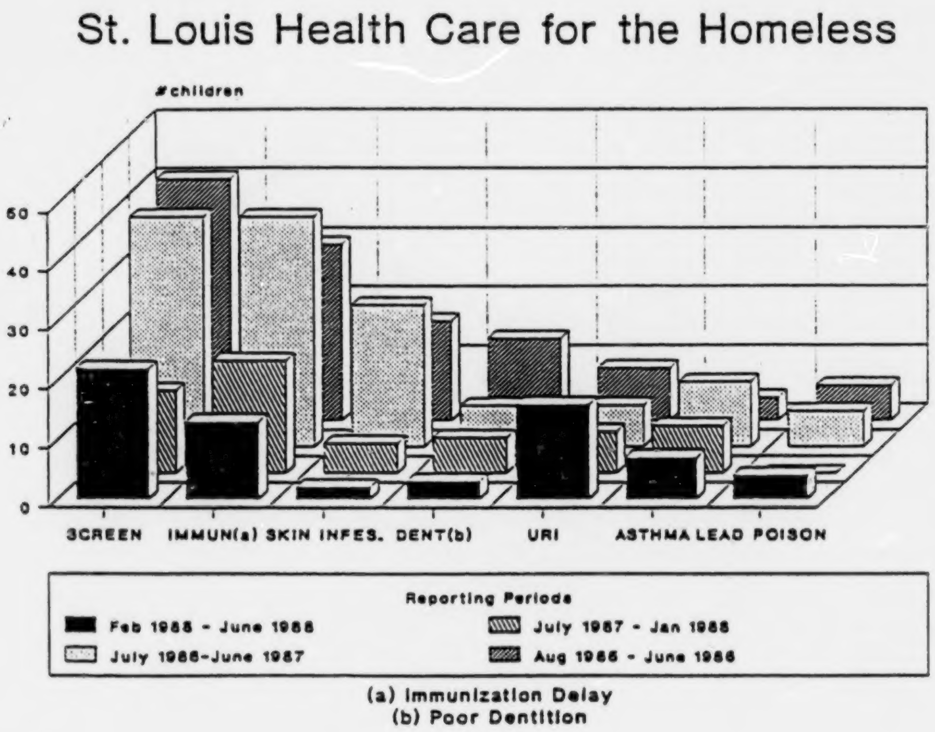
There are several places in the delivery model where tracking information were obtained. Simple counts of the number of persons who attended shelter screenings were made at each shelter after screening session. There were several instances, for example, where homeless individuals started the medical screening procedure only to refuse further treatment by walking out before a physical exam, refusing blood tests, urinalysis, or other services.

A second focal point in the tracking process concerned whether homeless individuals followed through in attending neighborhood clinics, in keeping appointments with hospitals, and in obtaining services from social agencies. This key linkage in the St. Louis project was a very difficult component to initiate and maintain. At one neighborhood clinic, care was taken by intake personnel to ask all patients about their current address. At another, larger neighborhood clinic, considerable effort was made to identify homeless individuals during a computerized intake procedure. There were policy questions concerning access to confidential patient information and matters of prioritizing input and output requests.

The question of successful outcomes, an issue which the third focal point addressed, was difficult to evaluate. Lacking the resources necessary to carry out comprehensive evaluation research, the St. Louis project made an effort to track homeless individuals by locating them at shelters after a thirty day period. A public health nurse and social worker obtained a referral list from the screening physician after each screening session. The referral list contains patient name, screening date, and reason for and location of referral. As time permitted, these professionals contacted shelter staff in an effort to locate referred homeless. A small sample, during rather cold early winter months, showed a referral success rate of approximately 40%.

Data on compliance with medication and other medical regimes were obtained by the social worker and nurse during their follow up contacts at participating shelters. In addition, an assessment was made about patient compliance for those homeless persons who kept scheduled return visit appointments with the physician on site. Below in Figure 2 are medical diagnoses of children seen by an HCHC physician.

FIGURE 2: Medical Diagnoses of Homeless Children



A sixty question pre-screening interview-questionnaire instrument was given to each shelter resident prior to a physical exam. The pre-screening instrument allowed for the collection of demographic, brief social history, and medical background data for each person examined by the physician. In addition, results from the physical exam (basic physical characteristics, principle and secondary diagnoses) were recorded for each participant. Finally, the physician noted whether medication had been prescribed or samples have been given out, and whether referrals were made. These data were then given to the supporting nurse and social worker for follow up.

Screening data were kept in locked portable filing boxes which are stored at one of the neighborhood clinics. The HCHC staff retrieved the portable files at the end of each week and transferred data from medical files onto a portable microcomputer. Care was taken to delete identifying information from the data file before entry into the computer data base. Backup disk copies of the screening data were made on a biweekly basis.

The data obtained throughout the tracking process at each focal point had variety of program and policy applications. The provision of tracking data to service providers acted as an immediate feedback mechanism so that minor adjustments could be made in the delivery of services. For example, knowledge about the length of time persons have been without residence, crosstabulated by age, sex, race, presenting problem, or related characteristics can be helpful in the selection of program alternatives.

Next the authors review the other model of computer-assisted shelter management in the St. Louis Family Haven shelter project.

Model #2: St. Louis Family Haven Shelter Impact of Services

Originally, the Homeless Continuum Model (Hutchison *et al.* 1981) was the foundation for the computer-assisted management model which began as an inductive social work practice method intended to conceptualize a computer-assisted approach to help families break the cycle of homelessness. A five-stage, casemanagement treatment plan was developed based on the following conceptualization: 1) Preventive Stage, 2) Crisis Intervention Stage, 3) Stabilization Stage, 4) Resettlement /Transitional Housing Stage, and 5) Community Reintegration Stage.

The United States Department of Health and Human Services in 1984 recognized the Homeless Continuum Model (HCM) as a successful expansion of shelter-based services beyond simply providing food and shelter. The rationale behind the model's progressive service stages was one of facilitating poor persons with family responsibilities through and out of homelessness toward family self-sufficiency. The general strategy was also adopted as part of the City of St. Louis' public response to the complex needs of the homeless.

The Homeless Continuum Model (HCM) was developed as a result of an ten year commitment by The Midland Division of The Salvation Army to establish rigorous, empirical support through computer-assisted management for programmatic and policy activities on behalf of homeless families. From its inception, the Homeless Continuum Model (HCM) was an innovative, technologically supported response to the growing problem of families made homeless through displacement and other causal factors.

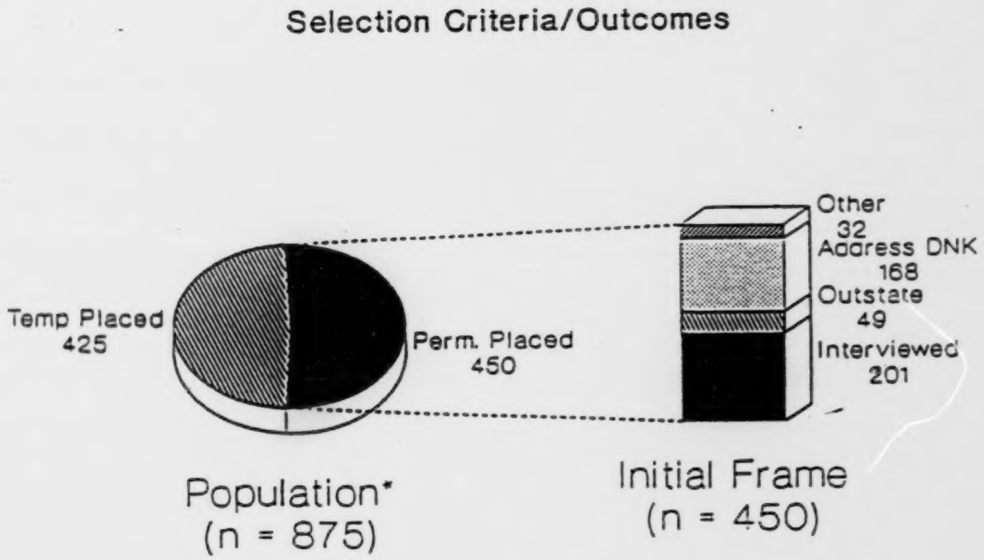
Since the opening of a 54-bed Salvation Army Family Haven in June 1979, this 60-day program was aimed at preventing, ameliorating, and correcting the undesirable effects of displacement on homeless families through an intensive casemanagement approach. For the period from 1983 through 1987 the authors developed and implemented a computer-assisted management evaluation model which tracked services and outcomes to 875 homeless families.

This evaluation was a cross-walked analysis of field interview data, computerized shelter records, and data from several state and local computer databases aimed at describing the current status, amount of stability, and basic functioning of former shelter families and children who had once been homeless. The design did not entail experimental manipulation, although retrospective comparisons on a limited number of key variables were carried out on a panel of families at two points in time. Likewise the study did not allow for strictly causal inferences, due partly to the non-experimental composition of the comparison groups and to an inability to utilize probability sample selection procedures. While there were individual longitudinal data elements which provided indications of changes over time, the basic design was descriptive.

Population and Sample

Out of 875 total families served, 450 families who had resided at the Shelter between 1983 and 1987 were selected from the computer database as eligible members of the initial target population to be located and interviewed in 1989. The study population of 450 cases consisted of families who received who received housing placements considered by staff to be permanent (Section 8, Other Public Housing, Rented or Purchased Housing, and other permanent arrangements). To this extent, the 450 out of the 875 total families served can be considered as the likely best-served families and children. Searches through state databases, city and county housing offices, and telephone directories produced a pool of 256/450 families in the general metropolitan area deemed eligible for contact for interviewing. Of these 256 families, 201 (78.5%) were interviewed at place of current residence, as shown in Figure 3.

FIGURE 3. St. Louis Impact Project Tracking Outcomes



These search procedures and the contact and interview process, in addition to selecting from among likely best served formerly homeless families, resulted in other systematic biases in the final data set of 201 cases. The final 201 interviewed families were by necessity selected by nonprobabilty (availability) sampling procedures, thus generalizations to the entire 450 best served formerly homeless families in the target population, and inferences beyond that to the 875 total served, should be considered guarded.

Residential Experiences

Data from the 201 field interviews showed an average time since leaving the shelter of 1294 days (median 1331 days), or about 3.5 years. Approximately 64% (129) of the former Shelter families who were interviewed resided in Section 8 housing at the time of the interview, 17% (35) were found in private rental or purchased units, 2% (4) were found in homeless shelters in the city, and the remainder were located in other public assistance settings.

Approximately 37% (76) reported that they were living in permanent residences which Shelter had located for them upon termination of shelter residence. Approximately one third (37%) of those interviewed reported living in only one residence since staying at the Shelter.

The mean number of different residences for all cases was 2.28. Reasons for selecting current residences included 34% (68) who said they had no other option, 17% (35) who cited quality of the housing unit; and 12% (24) who indicated size of the housing unit.

Monthly rent varied from none, for about thirty percent (61) of respondents in public, shared or other non-rental units to a high of $525. The mean rent, for those paying rent (140), was $119. In response to questions about unmet housing needs, approximately 57% (114) of those field interviewed expressed continuing housing needs, including 23% (27/114) who indicated need for furniture or appliances, and 22% (26/114) who sited the need for a larger housing unit. Other housing needs included help with utilities, maintenance/repairs, lower rent, and difficulties in the neighborhood.

Asked about problems encountered in applying for housing assistance, 61 (30%) indicated having applied for assistance, but no single problem dominated a list of difficulties which included expiration of Section 8 Certificate, ineligibility for Section 8, and high rents.

Family Demographics

Eighty percent (162) of those field interviewed were Afro-Americans and twenty percent (40) were Caucasian; the mean number of children per residence was 2.76 (median = 2); and the mean number of adults per family was 1.31. Seventy three percent (147) of those interviewed were families consisting of women with children. The remainder was comprised of 10% (21) married couples with children; 7% (15) extended families; 5% (10) lone females with no children; 2% (5) lone males with children; and .5% (1) couple without children.

For marital status, approximately 54% (108) were single at the time of the field interview; 19% (39) were separated; 13% (26) were divorced; 10% (10) were married; and 3.5% (7) were widowed. Forty percent (80) indicated increases in family size through births, while 11% (23) reported deaths in the family since their residence at the Shelter.

Level of education of the head of the household varied from a few cases with special education or some grade school, to 35% (71) with some high school education, 34% (68) with a high school diploma, to 16% (33) with some college education, and a few with more than a college education. Asked whether the Shelter had assisted in attaining the current education level, 14% (28) indicated that it had.

Ages of the interviewed former Shelter adults varied from 21 years old to 76 years of age, with a mean of 31.6 years old (median = 30). The number of additional total adults in the current family residence varied from 187 families reporting only one adult, to 13 cases (6.5%) where one additional adult was reported, and one case reported four additional adult residents. The mean number of total adults per residence was 1.31.

For interviewed adult family heads, 54% (109) indicated attending adult education or training programs since leaving the Shelter, including 36% (39/109) who attended job training, 19% (21/109) who attended GED classes, and 12% (13/109) who attended college.

Ninety two percent (186) of those interviewed had children living at home, and 93% (173/186) of those children had also resided at the Shelter. The mean age of all children was 8.9 years. Approximately 14% (26) of those interviewed said that they had children who had resided at the Shelter who were no longer living at home. About 15% (28) indicated that one or more of their children had lived elsewhere (either permanently or temporarily) since the family left the Shelter.

The number of total persons per family ranged from one to eleven, with an average of 3.8 persons per family (median = 4). About 18% (36) reported two persons, 23% (47) indicated three persons, 25% (50) indicated 4 family members, and 15% (31) indicated 5 total family members.

Approximately 86% (173) of those interviewed indicated having extended family within 100 miles of their current residence. A large number of those who did report having extended families, 47% (94) reported turning to extended family for support since leaving the Shelter. About 25% (51) indicated that they had shared residences with extended family since leaving the Shelter. The length of time for sharing residence varied from 1 to 72 months, and the mean length of time was 33 months.

Income and Employment

Twenty eight percent (56) report being employed at the time of the field interview, and of those, about two thirds (37/56) indicated that their work was full time. Hourly wages ranged from $2.00 to $12.00, with a mean of $4.93. Length of time in current employment ranged from two weeks to four years, with a average time on the job of 14 months. Only two of the 56 former best served Shelter residents indicated that the Shelter had been of assistance in locating current employment. A larger number, 46% (92) indicated having worked at some point since leaving the Shelter, with the mean number of months at previous employment at 9.7 months. The mean number of different jobs for those who had ever worked since leaving the Shelter was 2.1.

Concerning income, 60% (122) indicated AFDC as their principle source of income. Six percent (12) indicated that the Shelter had been of assistance obtaining the first source of income. The mean monthly income from all sources (including Food Stamps) was $521 (for those reporting income greater than $0.0) and $452 (median of $497), if those reporting $0.0 income are included. About 23% (47) of the former Shelter families reported losingna major income source since leaving the Shelter. all, 33 (16%) indicated no income sources, 33 (16%) indicated one source, 90 (45%) reported two income sources, 38 (19%) reported three sources, and 7 families (2.5%) reported four separate sources.

How Management Utilized Impact Data

Key Shelter Impact Questions

1) Where were formerly homeless families, who once received intensive shelter-based services, living up to 5 years later?

Data from a study of 201 formerly homeless families who had once resided in an intensively case managed family shelter indicated that approximately 64% (129) of the former shelter families resided in Section 8 housing; 17% (35) were found in private rental or purchased units; 2% (4) were found in homeless shelters in the city; and the remainder were located in other public assistance settings.

2) How many recipients of intensive shelter-based services experienced additional homeless episodes since leaving the shelter?

In our data about one sixth (33/201) of former shelter residents suffered from additional homeless episodes.

3) Were the families who did not reroot and instead became homeless again receive fewer shelter-based services than those did successfully reroot?

No, there was no empirical relationship between amount of shelter-based service and additional homeless episodes (t=.859, df=187 p=.39).

4) Did amount of time elapsed since receiving shelter-based services have any impact on whether families recycled?

Yes, families who had become homeless again had received services on an average of 3.5 years earlier, compared to those who had not been homeless again who averaged 1.5 years since services. (t=4.23, df=199, p=.004)

5) Did any one factor distinguish those who became homeless again from those who did not?

Yes, data show that those who received a Section 8 housing placement at termination from the shelter were much more likely to reroot and avoid becoming homeless again (6%), compared to those families who did not receive a Section 8 certificate (33%), as shown in Figure 4.

FIGURE 4: Correlations of Factors Associated with Rerooting of Homeless Families

	Rerooting	# of Moves	Chronic Cases	Amount Service	Housing Subsidy	Time Indep.
# of Moves	0.453**					
Chronicity	0.054	-0.093				
Amount/Serv.	-0.072	-0.161	0.045			
Housing Sub.	-0.363**	-0.333**	-0.074	0.212		
Time Indep.	0.202	0.344**	0.061	-0.434**	-0.499**	
Share/Family	0.335**	0.374**	-0.079	-0.152	-0.283*	0.211

* = .001 significance level (a)
** = .0001 significance level

(a) Probabilities were calculated utilizing the Bonferroni adjustment which takes into account the total number of correlations computed...thus minimizing overall Type I error.

6) What other factors were empirically related to formerly homeless successful rerooting?

We examined family supports including amount of education, employment status, participation in job training, and amount of income including AFDC/Food Stamps, and found that they were all unrelated to the likelihood of additional homeless episodes. Poor families who were residentially stable, however, were much less likely to ever be homeless again, compared to those who experienced multiple residential occupancies. (Chi Square 11.45, df=1, p < .001).

7) If residential instability was highly correlated with homelessness, did housing subsidies have any impact on residential stability?

Yes, those receiving Section 8 placements were much less likely to have moved than those not receiving a Section 8 placement, (Chi Square 10.94, df=1 p <.001). In addition, those receiving Section 8 placements moved less often than those who did not receive such a placement (t = 4.98, df = 199, p < .001).

Our management-evaluation project, one of the early attempts to look at the impacts of shelter-bases services on homeless families, found that while many formerly homeless families had successfully rerooted, those who had become homeless again suffered from general residential instability which was empirically related to lack of a housing subsidy, as noted in Figure 5.

FIGURE 5. Regression of Factors Tested Against Rerooting

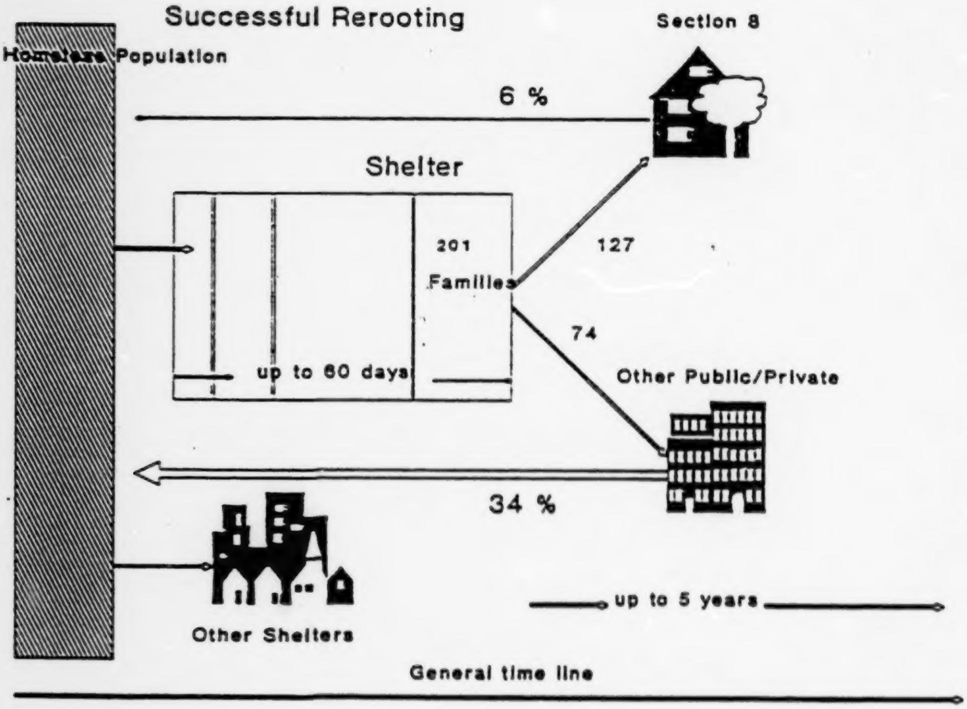
Variable	Coeff	Std.Error	Std.Coeff	T	Associated Probability
# of Moves	0.084	0.017	0.341	4.875	0.001
Amount/Service	0.001	0.001	0.027	0.395	0.693
Housing Sub.	-0.180	0.056	-0.234	-3.217	0.002
Time/Indep.	-0.000	0.000	-0.079	-0.992	0.322
Share/Family	0.139	0.057	0.163	2.434	0.016

Regression Overall F = 11.263   Associated Probability = .0001

Mult R: .539   Squared Multiple R: .290
Stand. Error of Estimate: 0.319

Contrary to initial expectations, we found that amount of overall shelter-based services was unrelated to rerooting, but type of housing placement was crucial (specifically Section 8 subsidies) in preventing additional homelessness. Finally, we found that the shelter based services apparently work in the short run (very few families immediately recycled) but the impacts of service are unlikely to last long term as indicated in Figure 6.

FIGURE 6. Successful Rerooting Based on Housing Subsidy


Successful Rerooting
Homeless Population
Section 8
6 %
Shelter
201
Families
127
74
up to 60 days
Other Public/Private
34 %
Other Shelters
up to 5 years
General time line

In our judgment these data point to the need for housing supports both to reroot those once homeless and to prevent additional homeless episodes. These data do not empirically support the use of intensive shelter services as a way to ameliorate homelessness.

It is a tenet of the authors that explicitly linking developing practice models such as the Homeless Continuum Model to computer assisted management is an essential component of accountable service to immiserated populations. Relevant and current computer-assisted outcome data are still required at all levels of public-private responsibility engaged in solving the multiple and complex issues surrounding homelessness. Next we look at implications of data from these computer-assisted management models in terms of the future of shelter services.

The Case For Downsizing Shelter-Based Services

Since the time of organized social services under the Elizabethan Poor Law, there have always been shelters and shelter-type services. Recent studies on high-risk once homeless families, however, have found that shelter-based services have not worked well as substantive longer term solutions to the multiple and intransigent societal problems of homelessness.

The English Poor Laws of the early 18th Century were more honestly straightforward than the modern United States Poor Laws of the 20th. The poor house and the alms house were meant to get the homeless out of sight. They were also designed to provide the least amount of support for the greatest number of poor people.

Today we witness a policy debate on how many and what kind of worthy and unworthy homeless inhabit our cities and countrysides (Blau, 1992). We have observed conservative policy makers terminologically diminishing or doing away with large segments of the unhoused and ill-housed (Weigard 1985). By twisting definitional parameters policy makers have managed to exclude hundreds of thousands of homeless individuals, families and children from our consciousness as homeless and poorly housed in need of prevention programs (Stretch, 1985). Thus out of sight politically, the homeless are too often out of mind programmatically. This must not continue.

Added to the political definitional confusion is the lack of clarity for homeless policy objectives. The government in the U.S. sees homelessness as primarily a state issue. The states, in turn, obligingly see homelessness as a local issue. To ease the social conscience of the body politic, a new chimerical beast has been invented. The new social chimera is privatization. Public-private partnerships are too often a facile neologism for dumping responsibility on churches, United Ways and other more eleemosynary private sector enterprises.

Shelters have developed complex specializations in serving the range of homeless populations. As noted here some shelters have even evolved elaborate medical, dental, psychiatric, and social services to meet basic needs. Most shelters are segregated by age and sex. It is an open question whether such segregation impacts type or amount of age or gender-based services. In addition, there are social-psychological implications of gender and age based allocation of public space which are only now beginning to be understood (Gutheil, 1992; Spain, 1992).

Sometimes shelters provide a full range of rehabilitation services which include community placement, followup, and subsidized housing and other care. At first blush the shelter movement, at least for some, appears to be doing the job. Little long term empirical support exists, however, for the effectiveness of even the best shelters. The most damning aspect of shelter provisions is that homeless persons who seek them out have absolutely no entitlements to their services and no redress if they are turned away.

With no clarity of social purpose and no common criteria for assessing social impact, shelter systems today may actually serve to hide potential solutions behind uncertain and inadequate Federal and State appropriations under the public-private partnership umbrella. Shelters at best are muddling through and the sad commentary is that as a society we allow ourselves to feel good about it.

Conclusion

Our position is that shelters and shelter-based services are in the main performing basically a maintenance function for the fundamental needs of the homeless. Shelter-bases services obscure the fact that we must commit vastly more resources and professionalism to forcibly eradicate the absolute shame of homelessness and its grinding up of human potential. It is boggling to the mind that we have an epidemic of homelessness in these United States that has become acceptable because we are unwittingly hiding the homeless from public view in shelters.

We therefore would place a good deal of the blame for fooling the public that something substantive is being done about homelessness squarely on such public-private but policy-naive efforts. Shelters give unwarranted social comfort to the rich while continuing to perpetuate a myth. The myth is that by graduating from a shelter, most of the homeless, through good old American bootstrapping, can return and reroot in their native communities. Our computer-assisted management data indicate that this was true only for those who received adequate housing supports.

REFERENCES

Bassuk, E. (1991). "Homeless families", *Scientific American*, 66-74.

Bidinnotto, R. R. (1991). "Myths about the homeless", *Readers Digest*, June, 99-103.

Blau, Joel (1992). *The visible poor: Homelessness in the united states*, New York: Oxford University Press

Comprehensive Housing Affordability Strategy, State of Missouri "FY 1993 Annual Plan and FY 1992 Performance Report", Missouri Housing Development Commission, September 18, 1992

Comprehensive Housing Affordability Strategy, "CHAS: The Final Rule", Special Memorandum, Washington, D.C., Low Income Housing Information Service, September 1992.

Elias, Robert (1986). *The politics of victimization: Victims, victimology and human rights*, New York: Oxford University Press

Gergen, K.J. (1990) "Therapeutic professions and the diffusion of deficit" *Journal of Mind and Social Behavior*, 353-367.

Gutheil, I.A. (1992) "Considering the physical environment: An essential component of good practice", *Social Work* 37, (5): 391-396.

Hutchison W. J., P. R. Searight, & J. J. Stretch (1986) "Multidimensional networking: A response to the needs of homeless families," *Social Work* 31 (6):427-430

Hutchison, W., Stretch, J.J., Smith, P. & Kreuger, L.W. (1992) "Social networking with homeless families" in Jahiel, (Ed) *Homelessness: A prevention-oriented approach*, Baltimore: The Johns Hopkins University Press.

Institute of Medicine (1988). *Homelessness, health and human needs*, Washington, D.C.: National Academy Press

Jahiel, R. I. (1987). "The situation of homelessness", in R.D. Bingham, R E. Green, and S.B. White (Eds.), *The homeless in contemporary society*, Newbury Park: Sage Publication.

Jakle, J. & D. Wilson (1992) *Derelict landscapes: The wasting of america's built environment*, New York: Rowen and Littlefield Publishers, Inc.

Karger, H.J. & J. Stoez (1990) *Welfare policy in america*, New York: Greenwood Press

Kreuger, L.W. & J.J. Stretch (in press). "Housing and homelessness" in Midgely (Ed) Controversial issues in social welfare policy, New York: Allyn and Bacon Publishers.

Kreuger, L. W. (1987). "Tracking health services for the homeless: Issues in information management" paper presented at the Annual Program Meeting of the National Institute for Information Technology: Health Related Services. Myrtle Beach.

Low income housing in missouri. (1987) Jefferson City, MO: Missouri Association for Social Welfare.

Spain, D. (1992) Gendered spaces, Chapel Hill: University of North Carolina Press

Stretch, J.J. (1985). "Children of the homeless" APM of the 3rd National Social Work Conference, New Orleans, LA.

Stretch, J.J. and L.W. Kreuger (1990). "The twig is bent: An empirical study of homeless children", Health Progress, June.

Stretch, J.J. and L.W. Kreuger (1992). "Five year cohort study of homeless families: A joint policy research venture", Sociology and Social Welfare. 19, #4.

Task Force on Survival Homeless in missouri, (1985) Jefferson City, MO: Missouri Association for Social Welfare.

University of Missouri-Columbia, Office of Social and Economic Data Analysis, (1989) The educational needs of homeless children: Toward a state plan.

University of Missouri-Columbia, (1989) 1989 Census of missouri homeless children, Columbia, MO.

Weigard, R. B. (1985). "Counting the homeless," American Demographics (December) 34-37.

Wright, J. D. (1989). Address unknown: The homeless in america. New York: Aldine De Gruyter.

PATTERNS OF RESIDENTIAL INSTABILITY: SOME EARLY FINDINGS FROM THE EVALUATION OF THE HOMELESS FAMILIES PROGRAM

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Presented at the 33rd annual National Association for Welfare Research and Statistics Workshop, August 10, 1993, Scottsdale, Arizona.

OVERVIEW OF THE HOMELESS FAMILIES PROGRAM

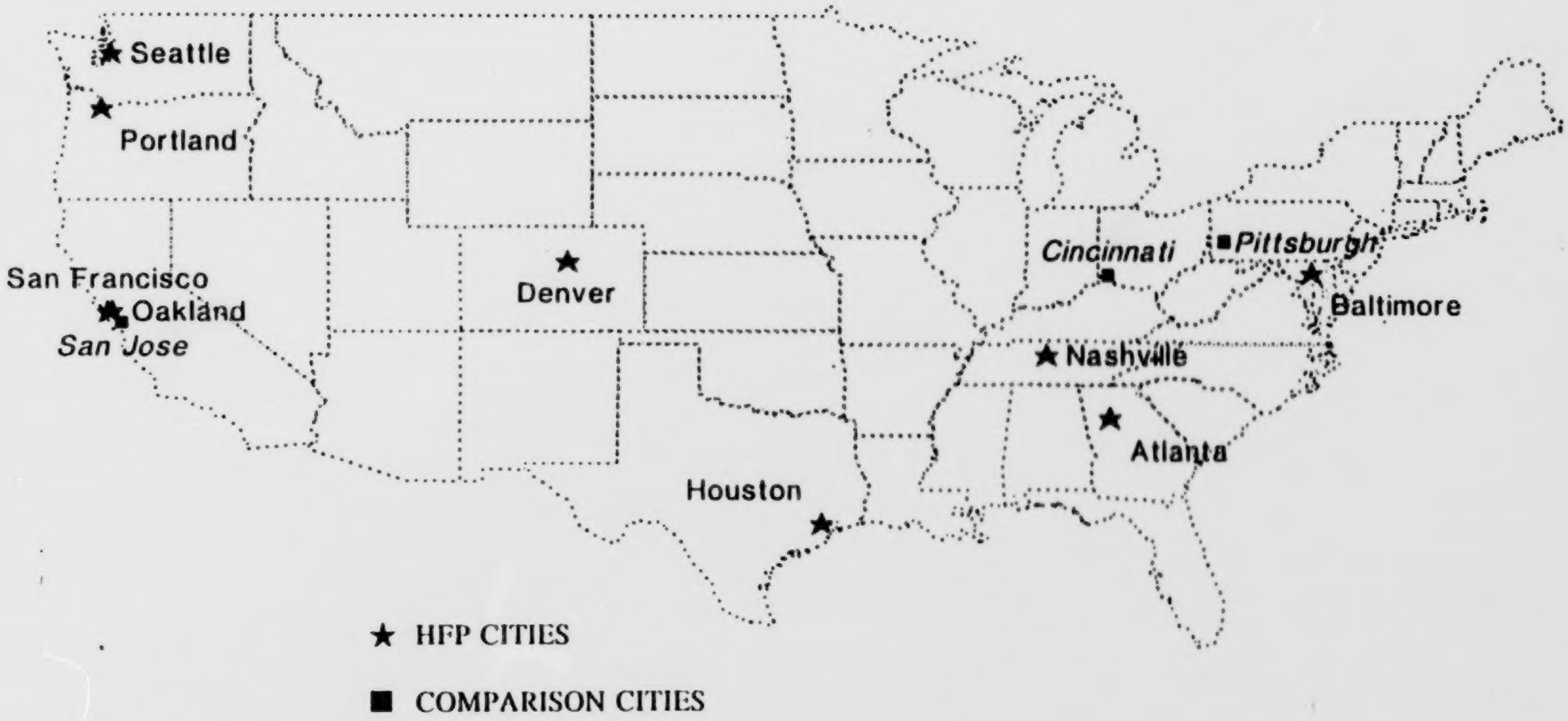
- JOINT EFFORT OF RWJF AND HUD
    - COORDINATION FUNDS
    - SECTION 8 CERTIFICATES

- FIVE YEAR DEMONSTRATION
    - 9 CITIES
    - 1200 FAMILIES

- GOALS:
    - BUILD SERVICE SYSTEMS
    - DEMONSTRATE SERVICES-ENRICHED HOUSING

Figure 3

HFP PROJECT AND COMPARISON CITIES


Seattle
Portland
San Francisco
Oakland
San Jose
Denver
Houston
Cincinnati
Pittsburgh
Baltimore
Nashville
Atlanta
★ HFP CITIES
■ COMPARISON CITIES

318

OVERVIEW OF THE EVALUATION DESIGN

- MULTIPLE COMPARATIVE CASE STUDY DESIGN

  - 9 HFP PROJECT SITES

    --SYSTEM LEVEL DATA

    --INDIVIDUAL AND FAMILY LEVEL DATA

  - 3 COMPARISON (NON-HFP) SITES

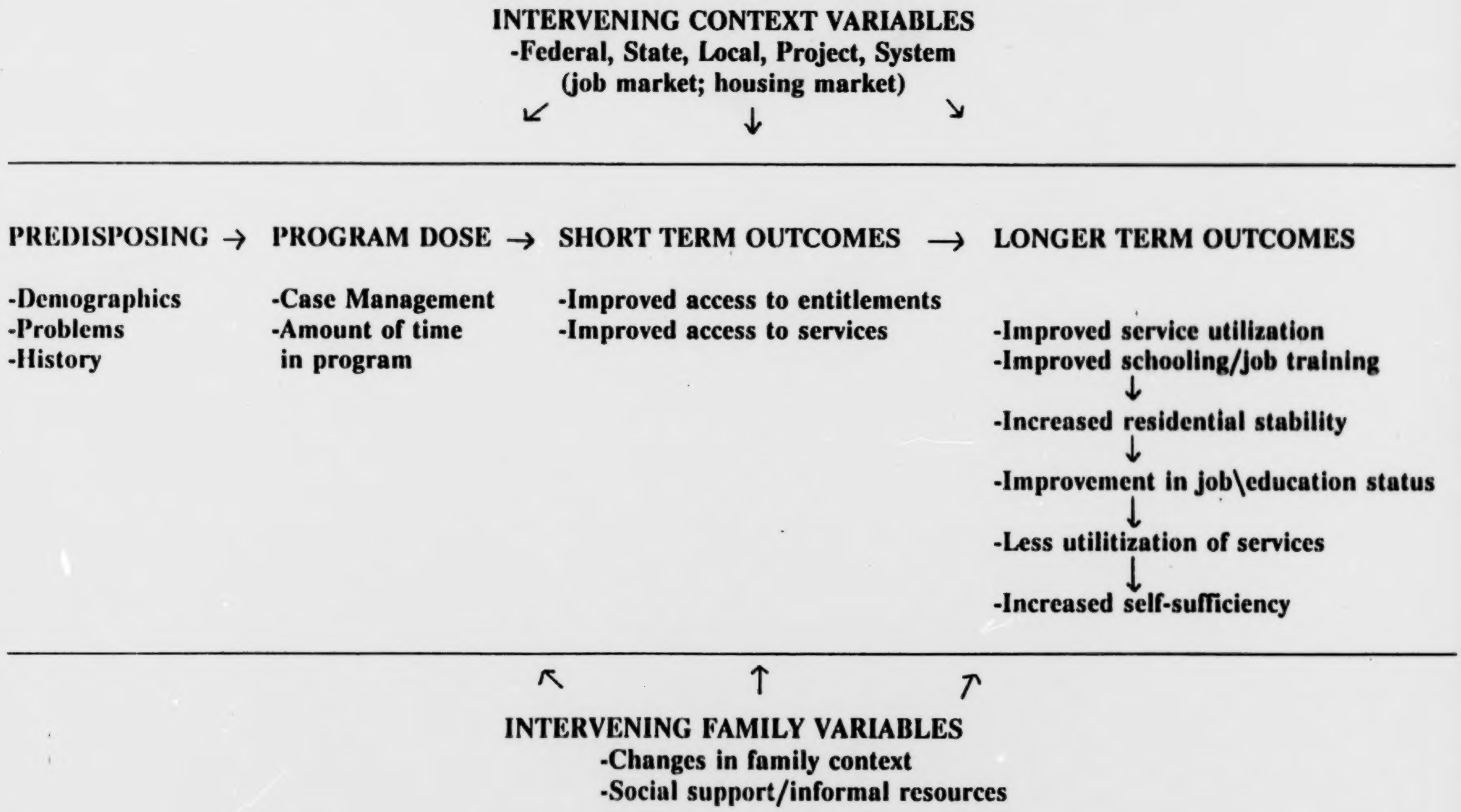
    --SYSTEM LEVEL DATA

MANAGEMENT INFORMATION SYSTEM

- DESIGNED FOR:
  - PROJECTS/NATIONAL PROGRAM
  - INDIVIDUAL CASE MANAGERS
  - EVALUATION

- MIS TRACKS EACH CLIENT THROUGH:
  - INTAKE
  - COMPREHENSIVE ASSESSMENT
  - MONTHLY CASE MANAGEMENT AND SERVICE DATA
  - QUARTERLY CHANGES IN STATUS
  - EXIT

PRELIMINARY CONCEPTUAL FRAMEWORK FOR FAMILY DATA ANALYSIS



INTERVENING CONTEXT VARIABLES
-Federal, State, Local, Project, System
(job market; housing market)
↙ ↓ ↘

PREDISPOSING → **PROGRAM DOSE** → **SHORT TERM OUTCOMES** → **LONGER TERM OUTCOMES**

PREDISPOSING
- Demographics
- Problems
- History

PROGRAM DOSE
- Case Management
- Amount of time in program

SHORT TERM OUTCOMES
- Improved access to entitlements
- Improved access to services

LONGER TERM OUTCOMES
- Improved service utilization
- Improved schooling/job training
↓
- Increased residential stability
↓
- Improvement in job\education status
↓
- Less utilitization of services
↓
- Increased self-sufficiency

↖ ↑ ↗

INTERVENING FAMILY VARIABLES
-Changes in family context
-Social support/informal resources

MANAGEMENT INFORMATION SYSTEM

- **DESIGNED TO:**
  - **HAVE CLOSE SITE CONTACT**
  - **BE A UNIFORM SYSTEM**
  - **COLLECT EXTENSIVE DATA ON:**
    - **CLIENT CHARACTERISTICS**
    - **PROJECT AND SERVICE PARTICIPATION**
    - **CHANGES IN THE FAMILIES**
  - **PROVIDE CONVERGENCE ON KEY ITEMS**

MANAGEMENT INFORMATION SYSTEM

- CHALLENGES:
  - MULTIPLE SITES, MULTIPLE CASE MANAGERS, MULTIPLE AGENCIES
  - MODEST PROGRAM FUNDING
  - COMPLEX, DIFFICULT-TO-REACH POPULATION
  - ROLLING ADMISSIONS OVER SITES WITH DIFFERENT STARTING POINTS
  - CONTINUAL NEED FOR CONTACT AND 'BOOSTER' SESSIONS

FAMILIES SERVED

- 963 FAMILIES EVER 'IN THE PROGRAM'
- RECRUITMENT VARIES:
  - SHELTERS ARE THE MOST FREQUENT REFERRAL SOURCES
- SELECTION CRITERIA:
  - LITERAL HOMELESSNESS
  - 'MULTIPLE PROBLEMS' SUCH AS:
    - DOMESTIC VIOLENCE
    - ALCOHOL/DRUG PROBLEMS
    - MENTAL HEALTH PROBLEMS
    - HEALTH PROBLEMS
    - INSUFFICIENT JOB SKILLS/EDUCATION

PRELIMINARY DATA

DESCRIPTION OF SELECTED HFP SITES

	EAST SITE	MIDWEST SITE	WEST SITE
LEAD AGENCY TYPE	PUBLIC	NFP	PUBLIC
HOUSING:			
# SECT. 8 - TEN.	110	128	91
# SECT. 8 - PROJ.	30	12	59
# OTHER	50		
CM STRUCTURE	1 AGENCY 7 CMs	7 AGENCIES 7 CMs	7 AGENCIES 10 CMs
AVE. AMT OF CM CONTACT IN A MONTH:			
# CONTACTS	3.4	4.7	6.9
# MINUTES	82 MIN	112 MIN	276 MIN

PRELIMINARY DATA

DEMOGRAPHIC PROFILE – SELECTED SITES

	EAST [N=123]	MIDWEST [N=129]	WEST [N=118]
FEMALE-HEADED (% SINGLE PARENT)	97%	77%	82%
AVE. AGE -- PARENT	27 YRS	29 YRS	29 YRS
CHILDREN			
AVE. #	2 CHILDRN	2 CHILDRN	2 CHILDRN
MEDIAN AGE	3 YRS	6 YRS	6 YRS
RACE			
% AFR. AMER	93%	23%	20%
% WHITE	7%	48%	65%
% HISPANIC	0%	17%	0%
% OTHER	1%	12%	15%
EDUCATION			
% LESS THAN HS/GED	65%	47%	39%

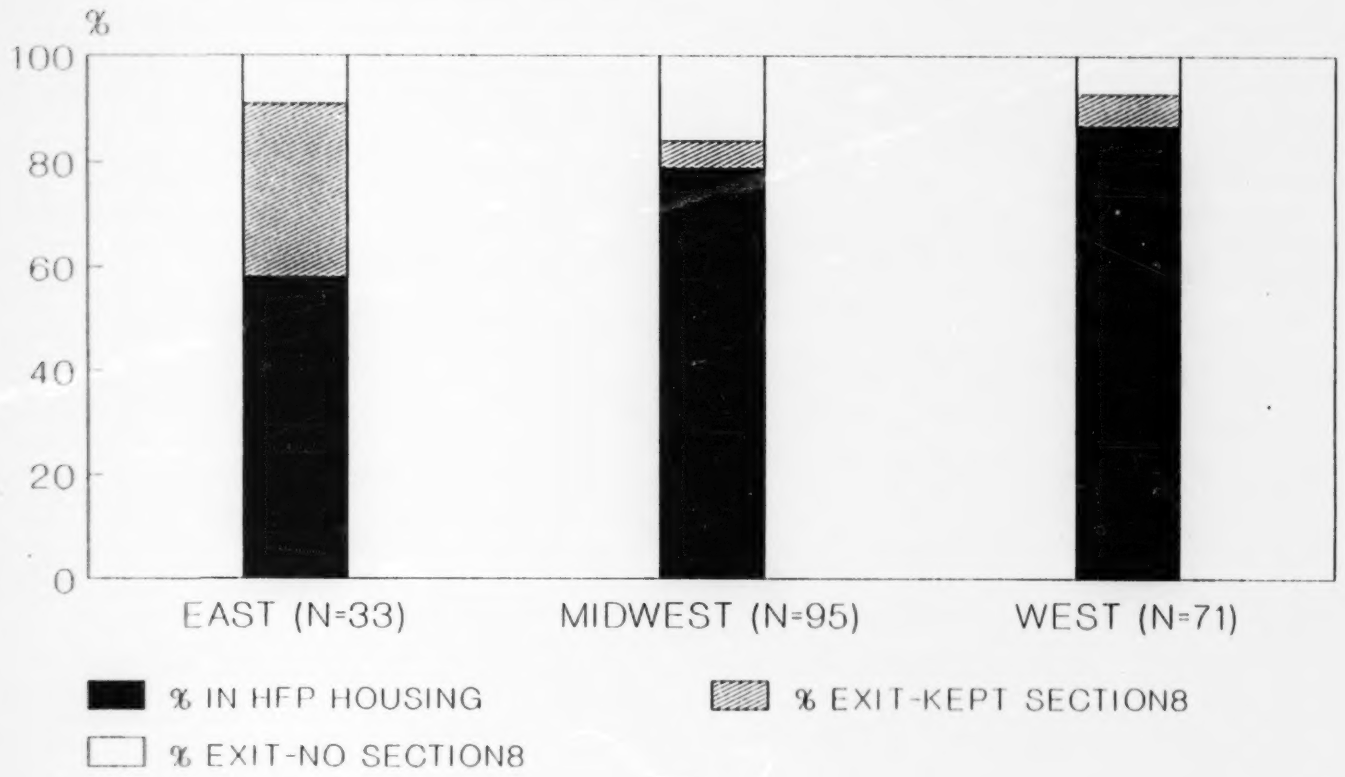
PRELIMINARY DATA

HOUSING HISTORY -- SELECTED SITES

	EAST [N=123]	MIDWEST [N=129]	WEST [N=118]
% HOMELESS AT LEAST 1X BEFORE	89%	67%	86%
IN PAST 2 YEARS (EXCLUDING TARGET EPISODE):			
AVE # OF			
LIVING SIT.	7	4	7
TIMES HOMELESS	2	1	1
TIMES DOUBLED	3	2	3
IN PAST 2 YEARS (INCLUDING TARGET EPISODE):			
AVE # MNTHS HOMELESS	6 Mnths	3 Mnths	3 Mnths
% HOMELESS AT LEAST			
6 MNTHS	33%	7%	12%
12 MNTHS	9%	2%	5%

Housing Status

One Year After Entering Housing



Includes Those Who Entered Before 6/92

High Risk and Delinquent Youth

Moderated by Kathryn A. Wilkerson
Arkansas Department of Human Services

South Carolina Delinquent Males: A Follow-Up into Adult Corrections - Trudie Trotti, South Carolina Department of Juvenile Justice

Issues in Cost-Outcome Analyses of Prevention Programs for High-Risk Youth - Shelli Rossman, Ph.D., Lisa C. Newmark, Ph.D., and Caterina Gouvis, M.S., The Urban Institute

Community-Based Employment and Service Integration Programs for Criminally At-Risk Youth: Issues in the Implementation of Three Federally-Funded Demonstration Programs - Caterina Gouvis, M.S., The Urban Institute, Emily Novick and Donald Oellerich, U.S. Department of Health and Human Services

BEST COPY AVAILABLE

South Carolina Delinquent Males: A Follow-Up into Adult Corrections

Jan Rivers, South Carolina Department of Youth Services, and Trudie Trotti, South Carolina Department of Juvenile Justice

Executive Summary

The study is a follow-up of 39,250 males born between 1964 and 1971, and having official delinquency records in South Carolina, to determine how many recidivated as inmates of the State Department of Corrections or as adult probationers. Adult agencies' records were checked through December 31, 1988, meaning that length eligibility for the adult system varied from less than one year to eight years, depending on the subject's date of birth. A total of 6,351 matches in the adult system were found, with the highest rate (27 percent) occurring in the oldest birth group (1964). Delinquent males born in 1967, selected for a special separate analysis, had a match rate of 20 percent after four to five years of adult eligibility.

Examination of the study population's characteristics as juvenile offenders, using one year, e.g., the 1967 cohort, revealed that males having only one court contact for delinquency were unlikely to recidivate as adults (probability = 13 percent). For subjects having at least one juvenile disposition of probation, the probability of adult criminality increased to 29 percent, while those institutionalized at least once as juveniles recidivated in adulthood at a rate of 56 percent.

The study also verified that substantial proportions of adult inmates and probationers born from 1964 to 1971 had juvenile records in South Carolina (45 percent and 27 percent, respectively), and that birth groups 1964 to 1971 of adult offenders under supervision fill out first with former juvenile delinquents.

INTRODUCTION

The purpose of the juvenile justice system is to prevent future delinquent and criminal behavior. When young people violate the law, the system attempts to balance justice and treatment needs in a manner that holds the juvenile accountable while providing the means for a change in behavior. The proportion of youth referred to Family Court who reoffend as adults is the ultimate indicator of the effectiveness of the system. If the percentage is low, we can conclude that some juvenile justice programs work -- either because they actively assist troubled adolescents in making a successful transition to adulthood or, because the system provides a measure of intervention/ supervision until youth mature out of antisocial behavior. If the percentage is high, a "rethinking" of philosophy and methods may be in order.

Once the rate at which ex juvenile offenders recidivate as adults is established, a host of other issues and questions emerge. Among these are:

1. What is the probability of adult criminality when the study population is subdivided by key social and judicial variables such as race, family history of criminal justice involvement, number of delinquency referrals and number of institutionalizations as a juvenile?

2. What social and judicial characteristics are significantly different when the study population is divided for comparison between delinquents with clear adult records and those who go on to adult criminal careers?

3. To what extent are former South Carolina juvenile delinquents represented in the populations of the adult criminal justice agencies -- South Carolina Department of Corrections and the Department of Probation, Parole and Pardons? and

4. How do former juvenile offenders in adult corrections differ from adult offenders with no delinquency history?

The following study begins to answer these questions based on a population of male offenders born between 1964 and 1971 and having an official delinquency history through the South Carolina Department of Youth Services (hereinafter DYS).

A Word About South Carolina's Juvenile Justice System

Studies of this kind invite comparison to research conducted in other states and municipalities. To some extent, the generalizability of these findings may be dependent upon the generalizability of South Carolina and its juvenile justice system. Over three million people reside in South Carolina, a predominantly rural and "small town" state with no major metropolitan areas. Within this total population the subgroup of children who are age eligible for delinquency has ranged from 420,000 to 450,000 between 1980 and 1988. In 1988, delinquency referrals to Family Court intake (17,158) represented about 4% of the age eligible grouping.

The South Carolina Department of Youth Services is the State agency which administers all community and institutional juvenile justice services, including: Family Court Intake and Detention Screening; Probation and Parole; Predispositional Evaluation; Institutional Supervision and Treatment; and Community Alternative Programs, both Residential and Nonresidential. This differs from other states which may incorporate juvenile justice programs with human services in a "cabinet" or "umbrella" organization, with the adult corrections agencies, or with county-level administration of intake, probation and parole.

While the juvenile justice systems in the majority of states have original jurisdiction over youth until their eighteenth birthday, South Carolina's maximum age of jurisdiction for delinquency and status offense matters extends only through the 16th year. Additionally, in South Carolina status offense matters (e.g., running away from home, truancy, and ungovernability) remain under Family Court jurisdiction, while in many other states social service agencies have the primary responsibility for these behaviors. For the past several years, status offenders have accounted for over 30% of South Carolina's Family Court intake referrals.

In South Carolina, a juvenile offender must be twelve years old before he can be committed to a correctional institution. Youth who commit heinous crimes (e.g., murder, criminal sexual assault) may be waived at any age to Circuit Court for trial as an adult after a full investigation by the Family Court. Waiver is also allowed for youth as young as 14 who are repetitive and serious offenders, although this provision is used only rarely, and for youth who are sixteen and charged with a criminal offense. The number of youth waived to adult court in any given year has not exceeded 20.

METHOD

This study was enabled by DYS's automated client information system, which contains the complete judicial history of each client and an array of family and social information. DYS also obtained data from South Carolina's two supervisory criminal justice agencies: Probation, Parole and Pardon (PPP) for adults under community supervision, and the Department of Corrections (SCDC) for institutionalized adult offenders. The data tapes from SCDC and PPP contained basic identifying information on each adult offender along with date(s) and the most serious offense associated with each commitment to the agency(ies).

Juvenile and adult records were matched by comparing name, sex, race and date of birth. Each client was counted only once for an unduplicated rate of adult recidivism. If a former juvenile offender had more than one adult sentence, only the more serious sanction was counted. The study does not yet provide a recidivism measure at the arrest level.*

*The South Carolina Law Enforcement Division has furnished this data; analysis is currently being conducted.

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The study population consisted of males born between 1964 and 1971 who had official delinquency records through the South Carolina Department of Youth Services. Females were deleted from this initial study because of their relatively low involvement in delinquent behavior, the high probability that a female's last name would change from the juvenile to the adult system and the small likelihood that female delinquents will become active in the adult system. Furthermore, since tracking was limited to juveniles with an official delinquency history in South Carolina and recidivism was checked only through South Carolina corrections agencies, the effects of in/out migration and death are not accounted for in the study.

It should be noted that the length of follow-up for recidivism varies according to birth cohort. Recidivism in the adult system was verified through December of 1988, meaning that the 1964 birth cohort was followed into the twenty-fourth year, (seven to eight years of eligibility for adult charges), while the 1971 birth cohort was followed into the seventeenth year, (one year or less of adult eligibility). A detailed analysis of one birth cohort is presented following the summary findings.

FINDINGS

Matches of Former Male Juvenile Offenders in the Adult System. Analysis shows that at age 24, with seven to eight years of eligibility, only 27 percent of juvenile offenders had recidivated as adults. Within the entire study population of 39,250 individual male juvenile offenders born between 1964 and 1971, 84% or 32,899, did not appear in the adult system. While the percentage will decrease somewhat as longer periods of follow-up occur, these preliminary results are promising. The large majority of youth referred to Family Courts for delinquency appear to grow into law abiding citizens, passing through the high risk young adult years without contacting the State's criminal justice agencies.

Six thousand three hundred and fifty-one (6,351) former South Carolina delinquent males, or 16% of the study population, were matched to an adult record. These included 2,447, or 6%, whose most serious adult disposition was community probation, and 3,904, or 10%, found incarcerated in adult institutions. The peak birth cohorts for matches overall were those containing the oldest adults: 1964, 1965 and 1966 at 27%, 24%, and 22% respectively. The younger cohorts born after 1966 likely will exhibit a similar match pattern once their members age through the twenty-fourth birthday.

Table I

Adult Recidivism Results by Birth Cohort of Previous South Carolina Juvenile Offenders

Birth Cohort	Age as of 12/31/88	Approximate Years of Adult Eligibility	Male Juvenile Offender Records	Clear Adult Record	Adult Corrections Match*
				n=32,899	n=6,351
1964	24	Eight (8)	4,215	**73%**	27%
1965	23	Seven (7)	4,630	**76%**	24%
1966	22	Six (6)	4,543	**78%**	22%
1967	21	Five (5)	4,462	**80%**	20%
1968	20	Four (4)	4,695	**83%**	17%
1969	19	Three (3)	5,212	**87%**	13%
1970	18	Two (2)	5,723	**90%**	10%
1971	17	One (1)	5,770	**97%**	3%
8 Year Total	-	-	39,250	**84%**	16%

Probability of Adult Criminality Based on Selected Social and Judicial Variables. For this analysis the study population of 39,250 former South Carolina male delinquents is divided into subgroups by single key variables to compute probabilities associated with adult criminality. Looking first at the social variables, proportionately more black male delinquents matched to an adult record than white male delinquents. Stronger associations with adult criminality also were found in: delinquents from single parent families and other living arrangements such as relatives' homes or foster care, those whose families have other delinquent or criminal members, those whose families are in lower annual income brackets, and those not attending school or attending in special education classrooms, as illustrated below:

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*"Adult Corrections Match" is defined as having a record with the South Carolina Department of Corrections or the Department of Probation, Parole and Pardons. Persons having records in both Departments were counted only once in Corrections.

Table II

Probability of Adult Criminality Based on Selected Social Variables Observed in S.C. Male Delinquents

Social Variable:	No. of Delinquent Records	No. of Adult Systems Matches	Probability of Adult Criminality Based on This Variable
Race:			
White	23,458	3,331	14%
Black	15,212	3,037	20%
Family Living Arrangement:			
Natural Parents	13,226	1,881	14%
Single Parent	12,916	2,405	19%
Parent/Stepparent	4,318	738	17%
Other	4,054	895	22%
Family Criminal/ Delinquent History:			
No	25,532	3,916	15%
Yes	7,840	1,837	23%
Family Annual Income:			
Less than $10,000	14,340	3,045	21%
$10,000 - $19,999	11,433	1,959	17%
$20,000 or greater	7,478	795	11%
School Attendance:			
Normal Classroom Setting	26,438	3,976	15%
Not Attending	4,193	1,144	27%
Special Education Program	3,384	690	20%
Other	695	155	22%

Looking at an array of judicial and processing variables, it is clear that the likelihood of adult criminality increases as male delinquents have sustained and repetitive contacts with the juvenile justice system. For example, in total delinquency referrals the chance of adult criminality more than doubles when males with only one referral (probability=10%) are compared to those with two or more referrals (probability=27%). The probability increases with each court contact to 45% for youth having six or more referrals. Similar patterns are seen in total number of delinquency adjudications and probation dispositions.

A dramatic distinction occurs in probability of adult criminality when the population is divided into youth who were institutionalized one or more times as delinquents (probability=46%) and those who were not (probability=14%). Furthermore, each incidence of institutionalization increases the likelihood of adult involvement as follows:

Judicial Variable	**Probability of Adult Criminality**	
Never institutionalized as a delinquent	14%	
One institutionalization	41%	46% Overall
Two institutionalizations	53%	
Three institutionalizations	58%	
Four institutionalizations	67%	

In offense categories, property and person type crimes generate the highest probabilities of adult criminality and status type offenses the lowest probabilities whether one looks at the first referral offense or the most serious adjudicated offense, which is shown below:

Judicial Variable	**Probability of Adult Criminality**
Most serious adjudicated offense = Act Against Property	29%
Most serious adjudicated offense = Act Against Person	28%
Most serious adjudicated offense = public order or other criminal	19%
Most serious adjudicated offense = status	12%

(Refer to Table III, Appendix, for Greater Detail.)

Factors Differentiating Male Delinquents Who Become Adult Criminals From Those Who Do Not. This section is a preliminary analysis splitting the study population to compare the 32,899 male delinquents with no adult record to the 6,351 male delinquents who have become active in the adult system as probationers or inmates of the Department of Corrections. All comparisons were subjected to a difference of proportions test to determine statistical significance. Comparisons were made on the basis of individual factors with no attempt at this time to determine how variables may cluster together to establish an "at risk" profile with high predictive validity.

Looking first at social variables, male delinquents with adult records are more likely to be black than their counterparts who have not entered the adult system. This difference is accounted for entirely within the Department of Corrections subset, while the racial distribution of former delinquents who appear only as adult probationers is identical to those with clear adult records. Other social factors associated with male delinquents now in the adult system are a higher incidence of single parent or other living arrangements at the time the subjects were juveniles, a higher incidence of criminal or delinquent behavior among family members and lower annual family incomes. In school attendance as a juvenile, the adult system matches are more likely to show non-attendance or special education status than those delinquents who have maintained clear adult records:

Variable	**Clear Adult Record**	**Adult System Match**	**SCDC Match**	**PPP Match**
Delinquent, Race = Black	38%	48%*	54%*	38%
Delinquent, Living Arrangement = Single Parent or Other Setting	47%	56%*	58%*	51%*
Delinquent, Family has Other Criminal/Delinquent Members	22%	32%*	34%*	29%*
Delinquent, Family Annual Income = <$10,000 at Time of Delinquency	41%	53%*	57%*	46%*
Delinquent, was Not Attending School or had Special Education Status	20%	30%*	33%*	26%*

(Refer to Table IV, Appendix, for greater detail)

Comparison by judicial and processing variables in the juvenile record reveals substantial differences between delinquents who have not recidivated as adults and those found in the adult system. The adult recidivist group has a much higher likelihood of recidivism as a juvenile, e.g., more than one delinquency referral, and one or more delinquency adjudications. Sanctions of probationary supervision and institutionalization as a juvenile also occur more frequently in the adult recidivist group than in delinquents having no adult record. The adult recidivists tend to begin their juvenile histories as more serious offenders -- charged with an act against person or property -- and are more likely, if adjudicated as a juvenile, for the most serious offense to have been an act against person or property:

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*Statistically significant; P=<.01; difference of proportions test; see Table XI, Appendix, for Z values.

Variable	Clear Adult Record	Adult System Match	SCDC Match	PPP Match
2 More Delinquency Referrals	32%	62%*	68%*	51%*
1 or More Delinquency Adjudications	44%	71%*	76%*	63%*
Probation as a Juvenile	31%	49%*	52%*	46%*
Institutionalized as a Juvenile	6%	24%*	30%*	14%*
Person or Property Offense Charged at First Referral	42%	51%*	54%*	46%*
Person or Property Adjudication**	57%	74%*	78%*	62%*

(Refer to Table V, Appendix, for greater detail)

Juvenile Offenders in the Adult System. In this section former South Carolina juvenile offenders who recidivated as adults are examined within the totality of the adult system.

It should be re-emphasized that the matches found reflect only adult offenders with delinquency records in South Carolina. Undoubtedly both adult agencies have offenders with delinquency records in other states. Similarly, adult corrections agencies in some other states will have offenders with South Carolina delinquency records. It is beyond the scope of this study to track in and out migration to and from other states.

The adult system population as of 12/31/88 included of 17,640 unduplicated individuals assigned to either SCDC or PPP whose dates of birth fall between 1964 and 1971. Of that number, 6,351 matched a South Carolina juvenile record for a rate of 36%, overall. Within the SCDC subset, 3,904 juvenile records were matched in a total of 8,692 inmate files for a rate of 45%. Looking at the remaining 8,948 files on adult probationers (with duplicates to SCDC removed), 2,447 juvenile matches were found for a rate of 27%.

It is interesting to note the degree of variation in match rate by cohort year. The youngest cohorts, 1970 and 1971, show overall match rates of 59% and 57%, respectively. Fully 65% of SCDC inmates born in 1970 are former juvenile offenders, compared to only 34% of inmates born in 1964. This suggests that birth cohort groups within SCDC (and PPP as well) fill out

* Statistically significant; P = <.01; difference of proportions test; see Table XI, Appendix, for Z values.

**Percentage based on juveniles having an adjudication, not all juveniles.

first variance with former juvenile delinquent offenders whose recidivism is occurring early in their eligibility for the adult system:

Table VI

Adult System Matches to South Carolina Delinquent Records by Birth Cohort

Birth Cohort	Adult System Files			SCDC Files			PPP Files	
	Total	S.C. Del. Record	% of Total	Total	S.C. Del. Record	% of Total	Total	S.C. Del. Record
1964	4,187	1,131	27%	2,066	710	34%	2,121	421
1965	3,559	1,108	31%	1,712	698	41%	1,847	410
1966	2,805	983	35%	1,360	608	45%	1,145	375
1967	2,441	908	37%	1,197	572	48%	1,244	336
1968	1,963	797	40%	958	498	52%	1,005	299
1969	1,418	687	48%	756	405	54%	662	282
1970	947	555	59%	477	311	65%	470	244
1971	320	182	57%	166	102	61%	154	80
8 YEAR TOTAL	**17,640**	**6,351**	**36%**	**8,692**	**3,904**	**45%**	**8,948**	**2,447**

On two variables, race and offense category, it is possible to compare adult offenders without delinquent histories to those who exhibit delinquent histories. In both SCDC and PPP, the offenders having a juvenile background are more likely to be white:

	SCDC/Not Delinquent	SCDC/ Delinquent	PPP/Not Delinquent	PPP/ Delinquent
Race = White	41%	46%*	60%	62%

The adult offense category in both agencies showed a somewhat higher propensity for property type offenses among former delinquents than other adult offenders without a delinquent history:

	SCDC/Not Delinquent	SCDC/ Delinquent	PPP/Not Delinquent	PPP/ Delinquent
Adult Offense = Property	55%	63%*	28%	33%*

*Statistically significant; P = <.01; difference of means test; see Table XI, Appendix, for Z values.

(Refer to Table VII, Appendix, for greater detail)

ANALYSIS OF THE 1967 BIRTH COHORT

There are two basic and related reasons why we have isolated delinquent males born in 1967 for separate analysis. The first concerns completeness of the juvenile offender data. Members of the 1967 cohort would have been ten to eleven years of age when South Carolina juvenile offender records were automated in mid-1978. Only rarely does the onset of delinquency predate the tenth birthday. Therefore, on "time-bound" predictor variables such as total number of delinquency referrals it is reasonably certain that entire juvenile records have been accounted for in the analysis. This assumption would be erroneous for some older youth in the 1964-66 birth cohorts.

The second reason for a separate analysis of the 1967 group is length of follow-up. Delinquents born in 1967 turned seventeen in 1984, allowing four to five years of tracking into adult-eligibility.** Had any of the younger cohorts been selected instead, the adult follow-up period would have been shorter and less adequate.

In other words, the 1967 birth cohort offers the best opportunity to analyze predictor variables in the delinquency history with reasonable assurance of complete juvenile offender data, and to determine the prevalence of recidivism based on a reasonable period of eligibility for adult sanctions. Assuming that the social and judicial characteristics of the 1967 birth cohort approximate those of the entire original population (containing birth cohorts 1964-1971 inclusive), we can conclude that the adult recidivism trends reported here are generalizable to the entire population.

Social and Judicial Characteristics of S. C. Delinquent Males Born in 1967. This section presents the social and judicial characteristics of 4,462 males born in 1967 and having an official delinquency record in South Carolina. The descriptions reflect individual and family characteristics as documented at the time of delinquency.

In racial composition the 1967 group was 59% white and 41% black. Family data indicated that 40% lived with their natural parents and 37% in single parent households. Eighty-one percent (81%) of families reported an annual income of less that $20,000, and 47% an income of less than $10,000. Most of these families, however, did not contain other delinquent or criminal members (77%). The delinquent subjects generally attended school in normal classroom settings (78%) with 11% not attending, either by choice or expulsion, and 9% in special education programs.

At the judicial level, most of the delinquent males born in 1967 evidenced only one delinquency referral to Family Court Intake (63%), and one-half of the group had no delinquency adjudications. The more chronic delinquency patterns, e.g., four or more court referrals, three or more

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**The cutoff for checking adult recidivism was 12-31-88.

adjudications, and two or more dispositions of probation, were observed infrequently (11%, 9% and 12% respectively). Ninety-one percent of the male delinquents born in 1967 were never institutionalized in a long term juvenile correctional facility, while 6% were committed one time. Multiple commitments were rare (3%). Property type crimes prevailed both in first referral offense (38%) and in most serious adjudicated offense (54%).

(Refer to Table VIII)

The social and judicial characteristics of delinquent males born in 1967 appear very much the same as those discussed in previous reporting for the original study population of delinquent males born between 1964 and 1971. As we examine probability of adult criminality in the next section, we can assume that the larger population would show a similar pattern given a four to five year follow-up for adult eligibility and equivalent (complete) juvenile offender data.

Probability of Adult Criminality Based on Selected Social and Judicial Variables. As noted in previous reporting, 908 members of the 1967 birth cohort of South Carolina delinquent males matched an adult record of either the S. C. Department of Corrections or the Department of Probation, Parole and Pardons, for an overall recidivism rate of 20% in the adult system. This section will present recidivism rates when the cohort membership is split according to key social and judicial variables.

Looking first at social variables, the probability of adult recidivism was higher for black former delinquents than white former delinquents. Adult recidivism also was more associated with former delinquents not living with both parents, those whose families had other criminal or delinquent members, and those whose families were in the lowest income bracket:

Characteristic	Probability of Adult Recidivism
Delinquent, Race = White	18%
Delinquent, Race = Black	25%
Delinquent, Living W/Natural Parents	18%
Delinquent, All Other Living Arrangements	23%
Delinquent, No Family Criminal History	19%
Delinquent, Family Criminal History	29%
Delinquent, Family Income $10,000 or More	18%
Delinquent, Family Income <$10,000	25%

Additionally, former delinquents who were not attending school as juveniles, and those attending but placed in a program other than normal classroom setting were more likely to resurface in the adult system that those whose schooling took place in regular classrooms:

Characteristic	Probability of Adult Recidivism
Delinquent - Attending School in Normal Classroom	19%
Delinquent - Not Attending School, Special Education or Other	30%

(Refer to Table IX for more detail)

Looking at the array of judicial and processing variables, it is clear that the likelihood of adult criminality increases as delinquent males have sustained and repetitive contacts with the juvenile justice system. For example, in total delinquency referrals the chance of adult criminality is more than 2.5 times greater for delinquent males with two or more referrals (probability = 34%) than for delinquent males having only one referral (probability = 13%). The probability increases with each court contact, exceeding 50% for five referrals and peaking at 60% for six or more referrals. Similar patterns are seen in delinquency adjudications, dispositions of probation, and temporary commitments for predispositional evaluations.

A dramatic distinction occurs in probability of adult criminality when the 1967 birth cohort of delinquent males is divided into youth who were institutionalized in long term correctional facilities at least once as juveniles (probability = 56%) and those never institutionalized (probability = 17%). Furthermore, each incidence of institutionalization increases the likelihood of adult involvement, as follows:

Variable	Probability of Adult Criminality
Never institutionalized as a delinquent	17%
Institutionalized at least once:	56%
Institutionalized one time	54%
Institutionalized twice	59%
Institutionalized three times or more	68%

In offense categories, person and property type crimes committed as juveniles generate the highest probabilities of adult criminality and status offenses the lowest, whether one looks at first referral offense or the most serious adjudicated offense, which is presented below:

Variable	Probability of Adult Criminality
Most Serious Adjudicated Offense=	
Act Against Person	37%
Act Against Property	33%
Public Order/Other Criminal	21%
Status Offense	17%

(Refer to Table X for More Detail)

SUMMARY AND IMPLICATIONS

This follow-up of 39,250 delinquent males into young adulthood is good news for juvenile justice practitioners. To find an adult recidivism rate of only 27% for the oldest cohort, followed for seven to eight high risk years indicates that either juvenile justice is doing its job of preparing troubled adolescents for adulthood or that youth learn from experience and mature into law abiding citizens in the large majority of cases.

The data also reveal that certain judicial, processing and social variables (race, family structure and income, school attendance status, number of delinquency referrals and adjudications, probation status as a juvenile, and institutionalization) generate higher probabilities of adult criminality and tend to differentiate male delinquents who recidivate as adults from those who do not. Given these basic indicators, the next step will be to determine what variables cluster together in the juveniles who become adult recidivists -- in other words to generate a valid high risk "profile". The capability to create this profile has obvious implications for developing preventive and interventive priorities within South Carolina's juvenile justice system.

As we look at the adult system, the importance of defining high risk and directing resources to lower the risk among associated children becomes very evident. It appears that juvenile delinquents who recidivate in adulthood do so rather quickly. As adults serving determinate sentences, they "stack up" in the adult system. The fact that at least 45% of Department of Corrections male inmates born between 1964 and 1971 came out of the juvenile justice system is especially compelling when the adult prison population is growing 13% per year and taxpayer dollars are being dedicated to new prison construction.

Profiling the 1967 cohort separately revealed that most had only one contact with South Carolina's Family Court system for delinquency, while half of the group had no delinquency adjudication. Property offenses tended to prevail over other types at the first referral and most serious adjudication levels. Over 90% of the group had never been incarcerated as juveniles in long term correctional facilities. Since these characteristics are consistent with the study population as a whole, it can be assumed that the entire population would display recidivism patterns similar to those of the 1967 cohort, given four to five years of adult eligibility.

The match rate of South Carolina delinquent males born in 1967 to adult offender records (SCDC or PPP) was 20%. In looking at the likelihood of adult criminality by single variables certain judicial factors, especially repeated processing and incarceration in long term correctional facilities generated high probabilities themselves without any more sophisticated statistical application to combine elements into a high risk profile.

While we may take some satisfaction in the knowledge that most South Carolina male delinquents born in 1967 did not recidivate as juveniles after the first Family Court contact, or as adults, there are compelling probability statistics on repetitive and institutionalized delinquent offenders that command our attention: On the third delinquency referral for males, the chance of adult criminal involvement becomes one in three; on the fifth referral, the odds increase to more than 50/50; and the chances exceed 50/50 with only one juvenile institutionalization. These "odds" very effectively underscore the need to bolster programming for early, effective intervention in order to prevent the recurrence of delinquent behavior and the internalization as juveniles of criminal life styles that carry over into adulthood.

For further information or copies of the Appendices, please contact the authors (see address list).

Issues in Cost-Outcome Analyses of Prevention Programs for High-Risk Youth

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Recent years have seen increasing public and professional concern over social problems such as substance abuse and criminal involvement, especially among youth. Programs serving early adolescent youth vulnerable to these problems emphasize a prevention approach in attempts to avoid or at least delay their onset. Evaluation research provides important information for assessing these programs by documenting program processes and impacts. Policymakers (and other key decision-makers) also need to know the economic effects, in terms of costs expended and benefits accrued, of these prevention programs.

While assessing the costs and benefits of any social program is a challenging task, the costs and benefits of prevention programs are particularly difficult to quantify as they emphasize non-events as outcomes (those negative occurrences the prevention program seeks to avoid). With early adolescent prevention programs which seek to prevent an occurrence expected up to several years in the future, the analytic difficulty is compounded by the need to collect longitudinal data, or make projections based on short-term data. A conceptual framework for enumerating, measuring, and monetizing the outcomes--intended and unintended--of a prevention program for youth will be presented in this paper. We will examine five outcomes of primary concern: youths' alcohol use, use of illegal drugs, and commission of status offenses, crimes against persons, and crimes against property.

The Strategic Intervention for High Risk Youth (SIHRY) program and its evaluation will be used as an example of applying this framework. SIHRY is designed to reduce and control drugs and related crime in high-risk neighborhoods, prevent at-risk youths from becoming involved in drugs and crime, and foster their healthy development. This program provides intensive case management services, family interventions, recreational and educational activities, mentoring, and access to a comprehensive array of ancillary services to at-risk youth ages 11 to 13 and their families. Enhanced criminal justice system services to these neighborhoods will also be offered to reduce illegal drug use and crime. These activities include community policing and coordination between SIHRY staff and justice system staff in monitoring youth under court supervision. The outcome evaluation design includes experimental and quasi-experimental comparisons of questionnaire data collected from youth and their primary caregiver at baseline and one-year follow-up interviews. Records data will also be obtained from schools, police, and courts.

This paper will present a conceptual framework that identifies the benefits that accrue to high-risk youth, their immediate social environment, and to society in general associated with delayed onset or avoidance of substance abuse, including alcohol and other drugs, and law-behaviors such as status offenses (e.g., truancy and running away), property crimes, and violent crimes. Benefits will be conceptualized as attainment of positive effects (e.g., earning a high school diploma) and as avoidance of negative consequences (e.g., not requiring arrest or court processing).

The framework will consider such categories as: reduced health care, emergency system, and criminal justice resource utilization; increased productivity; reduced property losses; improved quality of life; reduced transfer payments; and reduced administrative costs. A review of the literature will be presented, highlighting the crucial issues in implementing a "benefits" analysis of this nature. The discussion also will examine the feasibility of using cost estimation from the literature review to value the benefits of prevention programs for at-risk youth.

For a copy of the full report, contact the authors (see address list).

Community-Based Employment and Service Integration Programs for Criminally At-Risk Youth: Issues in the Implementation of Three Federally-Funded Demonstration Programs

Caterina Gouvis, M.S., The Urban Institute, Emily Novick and Donald Oellerich, U.S. Department of Health and Human Services

Rising levels of crime and violence among adolescent youth underscore the need to commit resources to create and evaluate innovative prevention and intervention programs for criminally at-risk youth. The high cost of institutionalization, combined with research concluding that training schools and prisons are ineffective in regard to rehabilitation, compound the need for flexible community-based programs capable of preventing delinquent and criminal behavior. There is no simple solution for helping these youth. The evaluation literature demonstrates that single-focus youth programs may not be effective in decreasing problem behaviors because many youth have multiple problems.

The research literature suggests that intervention efforts be multi-faceted, attempting to change negative behavior in all key areas that are related to delinquency and drug abuse. Successful programs are those which: 1) identify at-risk youth early and intervene early; 2) provide long-term and consistent intervention, with age-appropriate content changing over the years; 3) provide individualized attention and instruction, including intensive counseling as needed; 4) make comprehensive services available to youth, as needed, through on-site provision, collocation, or case management support; 5) include an emphasis on growth, skills enhancement, life options, and vocational orientation; 6) develop and use multiple channels of influence, including community-wide support and effort; and 7) provide a safe and stable physical environment for the program.

This paper will discuss the first year of operations of three federally-funded demonstration projects serving criminally at-risk youth in light of the seven features listed above. The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Labor (DOL) provided grants in 1991 to three local community-based organizations to develop and implement innovative, flexible and integrated services to high-risk youth aged 14-22 in a community-based, non-institutional setting. The ultimate objective is to assure that youth achieve "stability" and "independence" by "transitioning into meaningful employment, education (both secondary and higher) and independent living." The local agencies had submitted discretion in designing their programs, but had been encouraged to integrate a comprehensive array of services including "employment, education, community living, leisure, social, health, mental health, mentoring and respite services in a coordinated and proactive case management system." Thus, the projects are expected to have two main dimensions: youth employability development and service integration.

will be presented as a framework to discuss implications/lessons for other sites interested in developing employment-oriented programs for criminally at-risk youth.

The paper will focus on issues related to the design, objectives and delivery of services in the three demonstration projects with respect to the following issues:

- Clarity about who is and who is not a client;
- Client risk levels and their implications for program service offerings;
- Program orientation toward strengthening families and/or neighborhoods;
- Cultural content of program operations;
- Scope and variety of service delivery with particular emphasis on employment-related services; and
- Program choice and tradeoffs with respect to prevention/treatment orientation, activities/service orientation, youth-family-community orientation.

For a copy of the full report, contact the author (see address list).

Food Assistance Programs

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Cashing Out Food Stamps: Results from Washington State's Demonstration Program - Barbara E. Cohen, Ph.D., The Urban Institute

Who Uses Food Assistance Programs? Factors Associated with Use among the Elderly - Rebecca L. Clark, Ph.D., Barbara E. Cohen, Ph.D., Margaret M. Schulte, and Martha R. Burt, Ph.D., The Urban Institute

Cashing Out Food Stamps: Results from Washington State's Demonstration Program

Barbara E. Cohen, Ph.D., The Urban Institute

Washington State's welfare reform initiative, the Family Independence Program (FIP), incorporates food stamp benefits into public assistance checks, a form of food stamp cash-out. This paper documents the findings from the evaluation of the Washington State cash-out demonstration on household expenditures, food use, nutrient availability, and client attitudes toward check benefits[1]. We present some of the key background issues and research questions in the Washington State cash-out evaluation, as well as the basic research methodology, the key research findings, and a summary and implications of the findings.

Evaluation Background and Design

The cash-out demonstration is one component of FIP. FIP is a state-initiated alternative to the AFDC program and to the Washington Employment and Opportunities Program (WEOP)--the state work-welfare program component of AFDC that was in existence when FIP was implemented (July 1988). The major goal of FIP is to reduce poverty and dependence on welfare among families with children. To reach this goal, FIP offers enhanced employment and training opportunities to all clients to assist them in becoming economically self-sufficient. FIP also incorporates changes to some benefit features of AFDC and the Food Stamp Program, including the cash-out of food stamps for FIP participants. FIP provides clients with the actual cash equivalent of the food stamp coupon allotment.

The purpose of the cash-out evaluation was to **evaluate** the households' response to the form of food stamp benefits, giving special attention to the impact of cash-out on food expenditures and nutrient availability, as well as to participants' attitudes toward and experiences with check benefits. The evaluation is based on a quasi-experimental design of matched pairs of treatment and comparison sites. Five pairs of community service offices (CSOs) in the state were chosen as evaluation sites to be representative of the overall state welfare caseload. Five sites (one chosen randomly from each pair) were designated as treatment sites, and five sites (the other in each pair) were designated as comparison sites. Sites were matched on a number of criteria including rural or urban location, geographic area, local area employment, number of single-parent AFDC cases, out-of-wedlock birth rate, average monthly earnings of single-parent AFDC cases, ratio of single-parent to two-parent AFDC cases, and average earnings of all workers in designated occupations in the county. In the treatment sites, AFDC recipients were given cash

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[1] The terms check benefits and cash benefits are used interchangeably to refer to food benefits under the FIP cash-out program.

(added to their AFDC check) instead of coupons for their food stamp benefit amount. Non-AFDC food stamp recipients continued to receive coupons.

In the treatment sites, AFDC-eligible applicants to welfare who applied after FIP implementation were automatically enrolled in FIP. Recipients who were already receiving AFDC before FIP startup were given the option of either continuing to receive AFDC or changing to FIP. Some of these recipients chose to change to FIP, but a substantial proportion chose to continue to receive AFDC and food coupons, introducing a problem of self-selected treatment. To avoid bias, the analyses presented in this paper are based on data from the group that applied for welfare **after** FIP implementation--those who entered the FSP at a treatment site after the site had converted to FIP (399 households in the cashout sample) and those who entered the FSP at a control site after the matched treatment site had converted to FIP (381 households in the coupon sample). Data were collected from August through October 1990. In-person interviews with the main food manager collected detailed data on household expenditures, food use, shopping patterns, and attitudes about the benefit form.

Research Findings

Differences between the two samples are minor in terms of the key characteristics of household size and income. Total cash income (other than food benefits) averages $646 for check households and $687 for coupon households. AFDC income, which averages $398 for the check households and $362 for the coupon households, makes up more than half of the average household cash income. On average, food benefits constitute 29 percent of the combined total of cash and food benefit income for both groups of households. Average household size for the check and coupon samples is not different in a statistical sense for number of persons, number of Equivalent Nutritional Units (ENUs), or number of Adult Male Equivalents (AMEs) (Table 1). The biggest difference between check and coupon households in measures of average household size is in ENUs. Even here, the average household size for the check sample differs from the coupon sample by only 3.5 percent. The small size of these differences obviates the need for any complex adjustment based on post-stratification weighting, especially after scaling food use by an appropriate household size measure.

The following section presents key findings for the impact of cash-out on household expenditures (food and nonfood), nutrient availability of the household food supply, participation in other food assistance programs, and recipient attitudes toward food stamp checks and coupons.

Household Expenditures (Food and Nonfood)

Substantial differences were found in check and coupon household expenditure patterns. However, these differences were not in keeping with our expectations. Based on rules governing the use of food coupons in restaurants it was expected that cash-out might result in substantial shifts from expenditures for food at home to expenditures for food away from home. Since coupons may not be used to purchase food at restaurants, it was anticipated that cash-out recipients might purchase more food away from home while decreasing home food expenditures. The amount spent on food away from home remained extremely small for both samples, however, and any shift from food used at home to food used away from home was not statistically significant.

Home food expenditures account for 27.0 percent of the check household budget and 30.3 percent of the coupon household budget, a difference that is significant at the .01 level (Table 2). Shelter costs account for 41.5 percent of the check household budget and 39.5 percent of the coupon household budget, a difference that is significant at the .10 level. Transportation costs account for 10.2 percent of the check household budget and 8.6 percent of the coupon household budget, a difference that is significant at the .05 level.

Where food purchases are made also differs between check and cashout households (Table 3). The average share of food expenditures made at supermarkets is 5 percent greater for coupon households than for check households, a difference that is significant at the .10 level. The average share of dollars spent at neighborhood groceries is 7.8 percent for check households and 4.9 percent for coupons households, a difference that is significant at the .01 level. The average share of dollars spent at specialty stores is 4.8 percent for check households and 3.2 percent for coupon households, a difference that is significant at the .10 level.

Quantity, Value and Nutrient Availability of the Household Food Supply

Check households spent less on food than did coupon households. Households may lower their food expenditures by buying less food, less expensive versions of the same types and amounts of food, less expensive and different foods; or increasing the amounts of nonpurchased foods used at home to supplement their purchases. How the household lowers their food expenditures matters. If households simply buy less expensive versions of the same food items then cash-out is not affecting the household food supply. If, on the other hand, households are lowering their food expenditures by buying less food, or different food items, then nutrient availability is potentially affected. Finally, if households are lowering food expenditures by obtaining more nonpurchased food, cash-out may affect other food assistance programs.

Quantity of Food Used at Home per ENU (by Food Group). Cash-out was associated with a substantial and statistically significant difference in the amount of food used at home (Table 4). Check households used an average of 40 pounds of food per week per ENU, compared to the 44 pounds used by coupon households (a difference significant at a .01 level). More specifically, for 22 of the 32 food subgroups analyzed, cash-out was associated with a smaller quantity of food used at home per ENU. Among these 22 food subgroups, the differences for 7 food subgroups were significant at least at a .10 level. The 9 significant differences were not concentrated in similar foods. Instead at least one of the nine occurred in each of the five major food groups--vegetables and fruits, grain products, milk and milk products, meat and meat alternatives, and other food, evidence suggesting that there was no substitution among major food groups. Cash-out households used less (at statistically significant levels) of the following food subgroups: "other" vegetables (not potatoes or high-nutrient vegetables); condiments and mixtures; high-fiber flour, meal, rice, and pasta; bakery products (not bread); cheese; lower cost or variety meat; meat or meat alternative mixtures (prepared); sugar and sweets; and soft drinks, punches, and ades.

Money Value of Food Used at Home per ENU (by Food Group). The hypothesis that cash-out does not simply shift spending from one food subgroup to another is also supported by comparing the dollar value of food used per week per ENU for each food subgroup. For almost three-fourths of the 32 food subgroups, the money value of the food used at home was less for check than for coupon households (Table 4). Of these 24 subgroups, the difference between the check and coupon households was statistically significant for 7 food subgroups (.10 level or lower). Although the money value of food used at home was higher for check households for eight other subgroups, none of these differences was statistically significant.

Nutrient Availability (per ENU). When there is a difference in the amount of food available in a household, one might expect to see a similar difference in the availability of nutrients in that household. In general, the results bear this out. Cash-out appears to result in a statistically significant decrease in the availability of many nutrients (Table 5). Households receiving cash instead of coupons used less food, and as a result less energy, protein and other key nutrients were available to cashout thant to coupon households.

A primary measure of nutrient availability is that of food energy and protein availability. Inadequate availability of these macronutrients puts a household at risk of undernutrition. The mean availability of food energy and protein was significantly less (at the .05 level) for check than for coupon households, though mean availability still exceeded the RDAs. The mean availability of food energy per ENU was 132 percent of the RDA for check households and 144 percent for coupon households. The proportion of households with food energy less than the RDA was 31 percent for check households and 25 percent for coupon households (a difference significant at the .10 level). The mean availability of protein per ENU was 243 percent of the RDA for check households and 265 percent for coupon households.

Along with evaluating the availability of macronutrients, we also evaluated the availability of seven important micronutrients: vitamin A, vitamin C, vitamin B6, folic acid, calcium, iron, and zinc. These nutrients have established RDAs and have been classified by the Joint Nutrition Monitoring Evaluation Committee as a current or potential public health issue (DHHS/USDA, 1986).

Nutrient availability per ENU (expressed as a percentage of the RDA) for each of the seven micronutrients was lower for check recipients than for coupon recipients. The differences in availability of vitamin A, vitamin B6, folate, calcium and zinc were all significant at the .10 level or lower. But here again, even for check households, the average level of availability for the nutrients remained above the RDAs, ranging between 116 percent and 240 percent of the RDA.

Nutrient Density. Nutrient density refers to the amount of a nutrient present per 1000 kilocalories of food. The nutrient density of food used was not substantially different for check than for coupon households. The only statistically significant difference was for zinc (Table 5). Zinc, most often found in meats and whole grains, was significantly lower among check households at the .10 level.

Nutrient Availability per Dollar. Interestingly, nutrient availability per dollar for some nutrients was higher for check than for coupon households. Of the seven micronutrients evaluated, there was more iron, vitamin B6, and vitamin C available per dollar in check households, all significant at .10 level or better. The availability of food energy and protein per dollar was also higher for check than for coupon households: 4 percent higher for food energy and 5 percent higher for protein (both significant at a .05 level). An increase in nutrient availability per dollar for cash-out is consistent with household production models, where households have decreasing nutrient returns as they increase their food expenditures.

Participation in Food Assistance Programs

Program recipients may supplement and improve the nutrient availability of the food they purchase and bring into the home with several noncash sources of food. Two are federal food assistance programs--the Supplemental Food Program for Women, Infants and Children (WIC), and USDA commodity distributions. Given the lower income and food expenditure levels of check households, it would not be surprising if their participation in these programs was greater than the participation of coupon households. Survey responses indicate that a higher proportion of check than of coupon households did indeed use noncash sources of food. Of the check households, 20 percent reported participating in the commodities program compared with 8 percent of coupon households. For households with pregnant women or children younger than five, 50 percent of check households reported using WIC vouchers compared with 37 percent of coupon households. Both differences are statistically significant at the .01 level. However, there were no statistically significant differences in the value of food obtained with WIC vouchers (Cohen and Young, 1992).

Recipient Attitudes Toward Food Stamp Checks and Coupons

Members of both groups see advantages and disadvantages to both check and coupon issuance. The three most commonly mentioned advantages of checks over coupons are that checks can be used for other necessities (cited by 52 percent of check recipients and 42 percent of coupon recipients), that checks are less embarrassing (cited by 28 percent check recipients and 13 percent of coupon recipients), and that checks allow you to feel more dignified (cited by 18 percent of check recipients and 5 percent of coupon recipients). Consistent with findings on food purchasing patterns, 9 percent of check respondents and 8 percent of coupon respondents noted that checks offer more choice of food stores.

Recipient answers to questions about household budgeting highlight the perceived advantages of coupons over checks. Over 73 percent of coupon respondents agreed or strongly agreed that food stamps give more control over the household budget, compared with 35 percent of check households. Over 80 percent of coupon households agreed or strongly agreed that food stamp coupons are helpful in budgeting compared with 57 percent of check households.

Conclusions

The main purpose of the FNS cash-out demonstrations is to determine the advantages and disadvantages of cashing out food stamps. The results of the FIP cash-out demonstration in Washington State support arguments for and against cash-out. One of the concerns about cash-out is that recipient households might spend money otherwise earmarked for food purchases on nonfood items, which may decrease the quantity or quality of the food supply. Cash-out households in Washington State spent less on food, used less food, and had lower nutrient availability of key nutrients than coupon households. More specifically, the Washington State cash-out evaluation provides the following answers to the research questions listed at the beginning of this paper.

- Are the food expenditures of households that receive cash benefits different from those that receive coupon benefits? **Yes, households receiving cash benefits have lower food expenditures; 12 percent in dollars, 11 percent in dollars per ENU, 13 percent in dollars per AME.**

- Are the relative shares of major household budget items devoted to food and nonfood categories different for cash-out than for coupon households? **Yes. Cash-out households spent less than coupon households on, and devoted a lower budget share to, food purchased for home consumption, had similar patterns for food purchased for use away from home, and spent more on, and devoted a higher budget share to, shelter and transportation.**

- Is participation in other food assistance programs, such as WIC and commodities distribution programs, different for cash-out than for coupon households? **Yes. Cash-out households participated more in other federal food assistance programs including WIC and commodity distributions.**

- Is the nutrient availability of the household food supply different for cash-out than for coupon households? **Yes. Cash-out households had lower mean nutrient availability than coupon households for a number of important macro and micronutrients.**

- Is recipients' perceived control over food spending, difficulty in budgeting food expenses, and degree of stigmatization different for cash-out than for coupon households? **Yes. Both cash-out and coupon recipients perceived cash-out as reducing control over the household food budget, increasing the difficulty in budgeting food expenditures, and substantially reducing stigma. The restrictions in coupon use for nonfood items were seen as having advantages and disadvantages by respondents in both groups.**

Viewed as a whole the results from the Washington State cash-out evaluation demonstrate a **possible** process caused by cash-out. Food stamp coupons are a restricted form of benefit. They can be spent only on food items intended for home consumption, and can be used only at authorized stores. The form of food benefit has an impact on what households can purchase and where it can be purchased. Therefore, the FIP cash-out would be expected to have a direct impact on household expenditure patterns.

The results are consistent with this expectation. The check households spent less on food eaten at home than coupon households, and proportionately more on both shelter and transportation.

Differences in food expenditures appear to have resulted in significant differences in the dollar value and quantity of food used within the household, even after we controlled for differences in household size. There was no notable shift in the use of foods from one food group to another. Rather, quantities and money values of food used were significantly less for the check households over a broad range of food subgroups. Shifting away from food expenditures, cash-out households spent more on other necessities, especially shelter and transportation. The smaller quantities of food used by check households appear to have resulted in substantial reductions in nutrient availability.

These results are consistent with the following chain of events. Changes in household budgeting through increasing the choices of how households could spend their food benefit[2] led to reduced expenditures on food (11 percent less per ENU). Reduced expenditures led to reduced amounts of food purchased (9 percent less per ENU), which led to reduced nutrient availability (8 percent less per ENU), which led to an increased proportion of households failing to reach their RDA for food energy (6 percent more). It is noteworthy that the percent difference is reduced with each link in this chain--a pattern that supports the hypothesis that check households partly compensate for reduced food expenditures by increasing efficiency (nutrient availability per dollar spent) at each link in the chain.

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[2] More dispersed control over budgeting decisions, and greater freedom in where (and therefore when in the month) food items are purchased could also contribute to this result.

The FSP is intended primarily to assure needy households in the U.S. of the availability of a nutritious diet. The evaluation results suggest that this objective is met for most households regardless of the form of benefit. Average household nutrient availability from the household food supply was in excess of the RDAs for each nutrient evaluated for check and coupon households, although this measure refers to availability, not intake. Otherwise, the evaluation results strongly suggest that food coupons are significantly more effective at encouraging households to (1) increase food expenditures, (2) increase the quantity of food used, and (3) increase the average availability of some nutrients. In comparing the effects of coupon and check food benefits for welfare families, the question for policy makers is not so much whether differences between food coupons and food checks exist, but how to weigh the benefits and costs of these differences.

Table 1. Household Characteristics

	Check Sample	Coupon Sample	Percent Difference
Number of Persons in the Food Consumption Unit (FCU)			
Number of Persons	3.2	3.3	-2.9
Number of Equivalent Nutritional Units (ENUs)	2.8	3.0	-3.5
Number of Adult Male Equivalents (AMEs)	2.2	2.2	-1.1
Characteristics of the Main Food Preparer (percent)			
Female	82.2	89.8	-8.4**
Employed	16.8	16.8	-0.0
Less Than 35 Yrs Old	75.9	84.0	-9.6**
High School Completed	73.2	66.7	9.8**
Asian	5.0	1.3	282.0***
Hispanic	6.0	10.2	-41.2**
Black	5.0	10.5	-52.3***
White	79.7	72.7	9.6*
Other	4.3	5.3	-18.8
Household Income			
Total Cash Income Excluding Food Benefits ($ per month)	646.38	687.22	-5.9
Food Benefits Received ($ per month)	193.49	175.71	10.1***
Total Cash and Food Benefit Income ($ per month)	839.88	862.93	-2.7
AFDC Benefits Received ($ per month)	398.50	362.15	10.0**
Food Benefit as Percentage of Total Cash and Food Benefit Income (percent)	28.8	29.3	-1.6
Sample Size	399	381	

Source: Washington State Cashout Survey
Percent Difference is (Mean Check-Mean Coupon)/Mean Coupon.
* Statistically significant at .10 level.
** Statistically significant at .05 level.
*** Statistically significant at .01 level.

Table 2. Major Household Expenditures

	Mean Household Expenditures (dollars per month per AME)			Mean Household Expenditures (dollars per month)			Mean Household Budget Share (percent of total expenditures)		
	Check	Coupon	Percent[a] Difference	Check	Coupon	Percent[a] Difference	Check	Coupon	Percent[a] Difference
Food Expenditures									
Purchased Food at Home	106.73	128.85	-17.2***	234.22	266.30	-12.1***	27.0	30.3	-10.8***
Non-purchased Food at Home	28.73	29.07	-1.2	55.66	51.03	9.1	6.2	5.7	9.3
Food Away from Home	16.81	17.97	-6.5	34.03	32.17	5.8	3.4	3.3	2.9
Total Food	152.27	175.89	-13.4***	323.91	349.51	-7.3**	36.7	39.3	-6.7***
Non Food Expenditures									
Shelter Costs	182.34	188.59	-3.3	360.58	350.58	2.9	41.5	39.5	5.2*
Transportation	50.01	44.72	11.8	105.06	88.55	18.6*	10.2	8.6	18.7**
All Other	52.12	72.42	-28.0***	106.79	138.13	-22.7	11.5	12.7	-8.8
Total Non-Food	284.48	305.23	-6.8	572.43	576.33	-0.7	63.3	60.7	4.4***
Total Expenditures	**436.75**	**480.00**	**-9.0****	**896.33**	**925.84**	**-3.2**	**100.0**	**100.0**	**0.0**

Source: Washington State Cashout Survey

Percent difference = (mean check-mean coupon)/mean coupon.
* Statistically significant at .10 level.
** Statistically significant at .05 level.
*** Statistically significant at .01 level.
a/ percent differences need not add up.

Table 3. Household Shopping Patterns

	Check	Coupon	Percent Difference
Retail Food Expenditures by Source (Percent of Total Retail Food Expenditures)			
Supermarkets	84.4	88.8	-5.0***
Neighborhood Groceries	7.8	4.9	60.9***
Convenience Stores	3.1	3.1	0.0
Specialty Stores	4.8	3.2	46.6*
	100.0	100.0	

Source: Washington State Cashout Survey
Percent Difference is (Mean Check-Mean Coupon)/Mean Coupon.
* Statistically significant at .10 level.
** Statistically significant at .05 level.
*** Statistically significant at .01 level.

Table 4. Quantity and Money Value of Food Used at Home by Food Group (per ENU)

Food Group	Quantity of Food Used (lbs/week)			Money Value of Food Used ($/week)		
	Check	Coupon	Percent Difference	Check	Coupon	Percent Difference
VEGETABLES, FRUIT						
Potatoes	1.40	1.50	-6.45	.55	.61	-9.38
High Nutrient Vegs	1.65	1.58	4.33	1.29	1.18	10.08
Other Vegetables	2.29	2.58	-11.00 *	1.70	1.97	-13.66 **
Condiments, Mixtures	0.38	0.62	-38.37 ***	.58	.93	-37.24 ***
Vit. C-Rich Fruit	1.14	1.26	-9.34	.79	.86	-8.93
Other Fruit	3.67	3.87	-5.03	2.49	2.79	-10.63
GRAIN PRODUCTS						
Whole Grain/Hi Fiber Break. Cereal	0.46	0.42	8.95	1.00	.95	5.21
Other Breakfast Cereals	0.34	0.40	-16.41	.94	1.09	-14.08
Higher Fiber Flour, Meal, Rice, Pasta	0.09	0.13	-36.24 *	.14	.18	-20.82
Other Flour, Meal, Rice, Pasta	1.31	1.22	7.22	1.00	1.12	-11.05
High Fiber Bread	0.38	0.34	13.66	.27	.24	15.54
Bakery Products	1.05	1.15	-8.66	.73	.83	-12.05
Grain Mixtures	0.65	0.85	-23.37 ***	1.49	1.74	-14.26
MILK, CHEESE, CREAM						
Milk, Yogurt	10.49	10.92	-3.89	5.84	7.26	-19.60
Cheese	0.49	0.60	-17.87 **	1.17	1.41	-17.25 *
Cream, Mixtures Mostly Milk	0.64	0.71	-9.33	.69	.76	-10.27
MEAT AND ALTERNATIVES						
Lower-Cost or Variety Meat	1.33	1.61	-17.39 ***	2.19	2.61	-16.10 **
High-Cost or Variety Meats	0.93	0.85	8.64	2.11	1.98	6.63
Poultry	1.23	1.33	-7.47	1.52	1.86	-18.27 ***
Fish, Shellfish	0.60	0.50	19.45	1.37	1.27	8.45
Bacon, Sausage, Lunch Meat	0.79	0.89	-11.74	1.49	1.66	-10.35
Eggs	0.71	0.74	-3.35	.47	.50	-4.58
Dry Beans, Peas, Lentils	0.24	0.25	-2.24	.19	.20	-6.14
Mixtures	0.55	0.70	-21.64 **	1.46	1.80	-18.52
Nuts, Peanut Butter	0.22	0.22	0.25	.43	.47	-8.87

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Food Group	Quantity of Food Used (lbs/week)			Money Value of Food Used ($/week)		
	Check	Coupon	Percent Difference	Check	Coupon	Percent Difference
OTHER FOODS						
Fats, Oils	0.85	0.90	-4.73	.86	.89	-3.35
Sugar, Sweets	1.11	1.27	-12.95 *	1.18	1.37	-13.31 *
Seasonings	0.01	0.00	0.00	0.02	0.00	0.00
Soft Drinks, Punches, Ades	3.88	5.29	-26.71 ***	1.71	2.25	-23.92 ***
Coffee, Tea	0.15	0.13	20.20	.44	.42	5.97
Alcohol	0.63	0.59	7.17	.47	.38	24.49
Misc New Food	0.01	0.01	-0.53	.02	.02	24.42
TOTAL, ALL FOOD	40.27	44.11	-8.69 ***	37.30	42.40	-12.05 **
Sample Size	399	381		399	381	

Source: Washington State Cashout Survey
Percent Difference is (Mean Check-Mean Coupon)/Mean Coupon.
* Statistically significant at .10 level.
** Statistically significant at .05 level.
*** Statistically significant at .01 level.

Table 5. Nutrient Availability of Food Used at Home

	Check	Coupon	Percent Difference	
Food Energy				
% of RDA (per ENU)	132.0	144.0	-8.3	**
Availability of (kcal) per $	770.5	738.4	4.3	**
Protein				
% of RDA (per ENU)	243.2	265.1	-8.3	**
Availability (gms) per $	26.7	25.4	4.9	**
Availability (gms) per 1000 kcal	35.1	35.1	-0.0	
Vitamin A				
% of RDA (per ENU)	179.3	193.3	-7.2	*
Availability (ugRE) per $	356.3	340.2	4.7	
Availability (ugRE) per 1000 kcal	482.4	480.8	0.3	
Vitamin C				
% of RDA (per ENU)	239.7	255.6	-6.2	
Availability (mg) per $	36.0	33.0	8.9	**
Availability (mg) per 1000 kcal	49.2	48.1	2.2	
Vitamin B6				
% of RDA (per ENU)	152.4	163.0	-6.5	*
Availability (mg) per $	0.6	0.6	6.0	*
Availability (mg) per 1000 kcal	0.8	0.8	0.9	
Folate				
% of RDA (per ENU)	227.6	246.9	-7.8	*
Availability (ug) per $	88.4	83.9	5.3	
Availability (ug) per 1000 kcal	118.6	117.9	0.6	
Calcium				
% of RDA (per ENU)	124.4	135.3	-8.1	**
Availability (ug) per $	329.1	322.3	2.1	
Availability (ug) per 1000 kcal	444.9	456.0	-2.4	
Iron				
% of RDA (per ENU)	169.2	177.8	-4.8	
Availability (ug) per $	6.1	5.6	8.9	**
Availability (ug) per 1000 kcal	8.3	8.0	3.9	
Zinc				
% of RDA (per ENU)	116.2	130.2	-10.8	***
Availability (ug) per $	3.8	3.8	1.5	
Availability (ug) per 1000 kcal	5.1	5.2	-3.3	*
Sample Size	399	381		

Source: Washington State Cashout Survey
Percent Difference is (Mean Check-Mean Coupon)/Mean Coupon.
* Statistically significant at .10 level. ** Statistically significant at .05 level. *** Statistically significant at .01 level.

Table 6. Respondent Comparisons of Food Checks and Food Coupons (percentage)

	Check	Coupon
Advantages of food checks		
Can be used for other necessities	51.4	43.3
Don't feel embarrassed	27.8	12.6
Allows you to feel more dignified	18.3	4.5
Advantages of food coupons		
Ensures benefits are spent on food	53.4	67.2
Can't be used for other necessities	6.5	6.6
Easier to budget food expenses	5.5	14.4

Source: Washington State Cashout Survey

Table 7. Control Over How Food Benefits Get Spent
(percentage by number of parents in unit)

	Check	Coupon	Percent Diffference
Single Parent Families			
Food Preparer Controls Food Benefits	95.3	97.5	-2.2
Sample Size	322	323	
Two Parent Households			
Food Preparer Controls Food Benefits	35.5	46.4	-23.5
Sample Size	76	56	
All Households			
Food Preparer Controls Food Benefits	83.9	89.9	-6.7 **
Sample Size	398	379	

Source: Washington State Cashout Survey
Percent Difference is (Mean Check-Mean Coupon)/Mean Coupon.
* Statistically significant at .10 level.
** Statistically significant at .05 level.
*** Statistically significant at .01 level.

Who Uses Food Assistance Programs? Factors Associated with Use among the Elderly

Rebecca L. Clark, Ph.D., Barbara E. Cohen, Ph.D., Margaret M. Schulte, Martha R. Burt, Ph.D., The Urban Institute

Introduction to the Survey

The research presented here is part of a larger Urban Institute project, initiated in 1992, exploring hunger and food insecurity among the elderly. The project consists of both a national survey and local community surveys. This project is supported by the Phillip Morris Companies, Inc. and is being done in cooperation with a group of representatives from national aging and hunger organizations. Because a significant portion of the elderly population has low incomes, limited mobility, or poor health, it is likely that elderly Americans have more trouble getting adequate food than the general population. Nevertheless, existing data touching on these issues is sparse and out-of-date. Also, very little research has been done specifically on participation among the elderly in food stamps, home-delivered meals or congregate meals.

The data used in this research were collected through a mail survey sent in June 1992 to a sample of 3500 households, each containing at least one individual aged 65 or older. The final sample includes 2734 individuals, a 78 percent response rate. We used a stratified random sampling procedure by age and income to assure that we had sufficient numbers of low-income and very old (over 85) individuals.

Assigned weights were developed from age, income and geographical location data gathered in the March 1991 Current Population Survey with the intention of making the sample representative of the 31.2 million elderly individuals in the United States. To see whether the weighting procedures have had the desired effect, we compare some of our results to data from the 1990 Census. Table 1 shows the proportion of the U.S. population 65 and older with a given characteristic according to the Census data, and the parallel proportion from our weighted data. As this table shows, our weighted sample contains somewhat more females, it somewhat underrepresents whites, and overrepresents blacks and others (though the numbers are too small to be able to conduct separate analysis for people of other racial groups), while seriously underrepresenting Hispanics. Our sample contains a higher proportion of elderly who live alone and a lower proportion of people reporting functional limitations.

In addition to this national mail survey, in-person interviews are being conducted with seniors in areas with high concentrations of low-income elderly in 16 local communities.

Table 1. Comparison of 1990 Census Data and Weighted Sample Data on Selected Variables, for Persons 65 and Older

Population Characteristic	1990 Census	Weighted Sample
Sex		
Male	40.1	32.6
Female	59.9	66.8
Race		
White	89.1	79.4
Black	8.0	14.9
Other	2.8	5.7
Hispanic Origin	3.7	0.8
Live Alone	28.2	38.3
Activity Limitation		
Mobility limitation	31.6	
Self-care limitation	11.9	
Mobility and/or self-care	35.7	
One or more Functional Limitations		25.9

Local aging and hunger agencies in these communities are conducting interviews of 200-350 elderly individuals. Communities were selected to achieve a balance of urban and rural locations, and of racial/ethnic populations. We have helped each local community to develop a sampling plan that will produce data representative of the area (rather than being overweighted with people already connected to services for the elderly). The Urban Institute has also provided two days of training to the local agencies, and is available for unlimited telephone technical assistance and for limited on-site consultation when necessary. The agencies are using an expanded version of the national survey. This expanded questionnaire incorporates many additional questions that local Area Agencies on Aging and other local agencies have indicated they want to know about.

A series of three papers has been written on analysis of the national survey. The first, entitled *Hunger and Food Insecurity Among the Elderly*, presents our estimates of the extent and nature of food insecurity among elderly Americans. The second paper, which presents factors associated with use of food stamps, home-delivered and congregate meals, is entitled *Who Uses Food Assistance Programs?: Factors Associated with Use Among the Elderly*. The final paper, *Factors Associated with Food Insecurity Among the Elderly*, looks intensively at factors that might have a causal association with the experience of food insecurity. The following presentation is drawn from the first two papers.

The Extent and Nature of Food Insecurity

The concept of food security is defined as the "condition under which individuals can obtain a culturally acceptable, nutritionally adequate diet, through non-emergency food channels, at all times." People experience food insecurity when their home sometimes lacks adequate food, when they cannot always afford to buy enough food, or when they cannot always get to markets or food programs.

To measure food insecurity we asked the following four questions:

1) Have there been days when you had no food and also had no money or food stamps to buy food?

2) Do you ever have to choose between buying food and buying medication?

3) Do you ever have to choose between buying food and paying your utilities or rent bills?

4) In the past month, did you ever skip any meals because there wasn't enough food, enough money or food stamps to buy food?

As Figure 1 shows, 4.8 percent of our sample, or the equivalent of 1.5 million elderly americans have experienced at least one of these circumstances indicating hunger or food insecurity in the last six months (or one month for skipping meals).

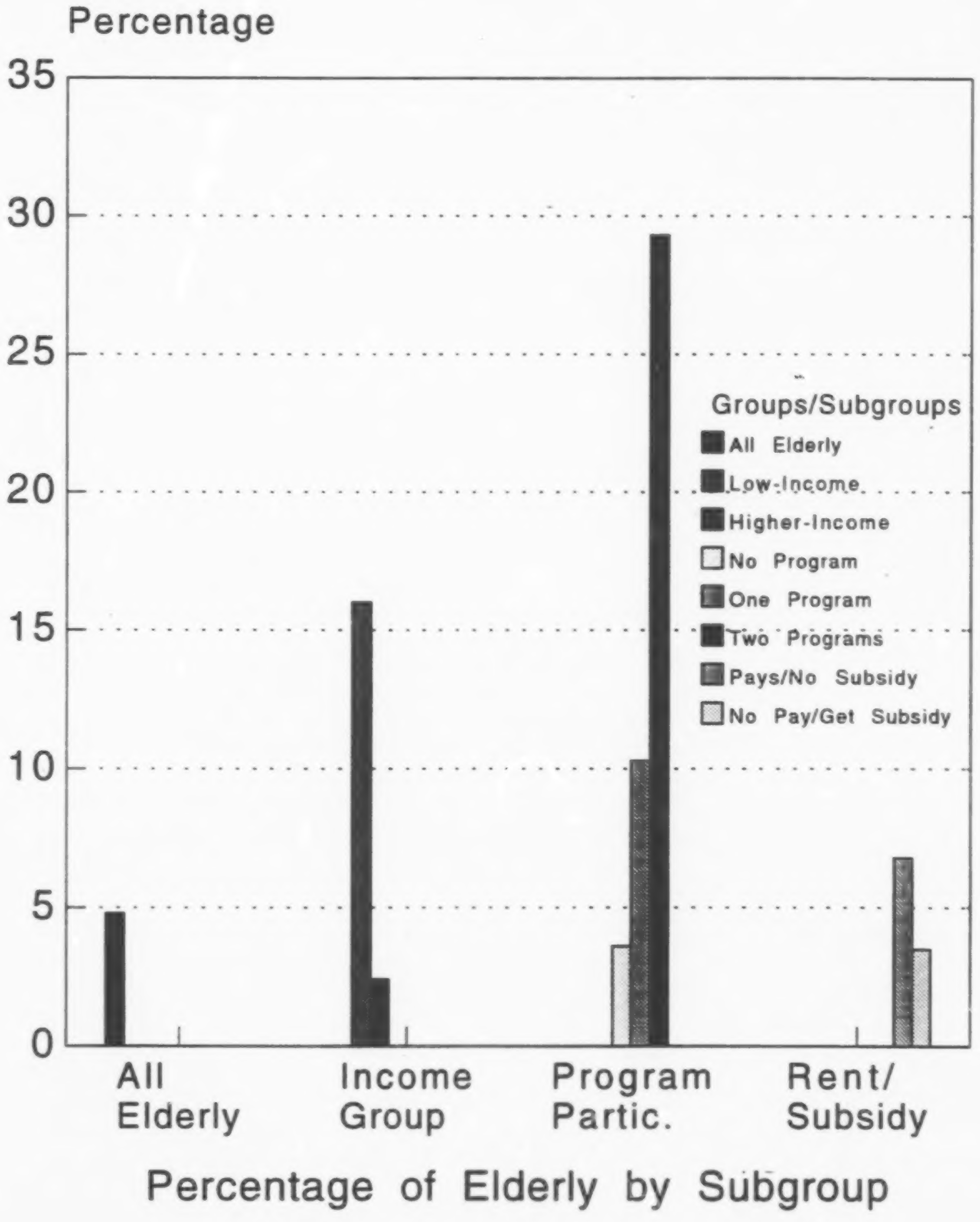
Also shown in this figure is that low-income elderly individuals were more likely than those with higher incomes to report food insecurity. Sixteen percent of low-income elderly reported at least one instance of food insecurity compared to 2.4 percent of those who are not low-income.

Other measures suggesting need are also associated with food insecurity. 6.8 percent of the elderly who pay rent or mortgage without a subsidy reported food insecurity compared to 3.5 percent of those who either receive a rental subsidy or do not make a rent or mortgage payment.

Finally, 29 percent of those participating in two or more food assistance or meals programs and 10.3 percent of those participating in one program report food insecurity compared to only 3.6 percent of those not participating in any program. It may seem contradictory that the people participating in food assistance programs are more likely to report food insecurity than those who do not participate in any programs. But this finding is consistent with other

FIGURE 1

Percentage Experiencing At Least One Circumstance of Hunger or Food Insecurity in Past Six Months



data from the Community Childhood Hunger Identification Project collected by the Food Research and Action Council on the relationship between hunger and program participation. The findings suggest that people who use food assistance programs have truly severe food access and food security problems--problems so great that the programs to which they turn cannot completely compensate for the lack of other resources in their lives to assure an adequate food supply. This suggests that these programs reach the right people, but that program resources are not enough to solve their food security problems.

Participation Rates among Those in Need

In the following section, we look at the percent of elderly whose characteristics would suggest that they need food assistance programs but do not use them. We use five measures of need: the existence and number of measures of food insecurity; the existence and number of functional limitations; income relative to household size; the existence and number of eating-related health problems; and whether an individual lives alone.

For each measure of need, we look at the percentage of elderly who according to our approximation of eligibility are eligible but do not receive benefits. As Table 2 shows, among low-income elderly, nearly 87 percent do not receive food stamps. Among those with very low incomes, fewer than 1 in 5 receive food stamps. Even among those who report food insecurity, nearly three quarters do not receive food stamps.

Secondly the table shows that the vast majority of elderly individuals with at least one functional limitation--95 percent--do not receive home-delivered meals. Furthermore, 9 out of 10 individuals who have experienced food insecurity do not receive home delivered meals. Of all the measures of need we examine, only one--having three or more functional limitations--is associated with a probability higher than 10 percent of receiving home delivered meals. But as the table shows, six out of every seven individuals with three or more functional limitations is not getting home-delivered meals.

The table also shows that approximately 1 in 10 elderly individuals in our sample uses congregate meals. The vast majority of those experiencing food insecurity--82 percent--do not attend congregate meals. Two out of three elderly individuals who report three or more indicators of food insecurity do not attend congregate meals. Five out of every six elderly individuals who live alone do not attend congregate meals.

Finally, as the last column of the table shows, most elderly who report food insecurity--63 percent--do not receive benefits from any of the programs we consider. Even among those who report three or more circumstances of food insecurity, nearly half do not participate in any of these programs.

Table 2. Percent of eligible elderly who do not use food programs

	Percent of low income elderly not using food stamps N=754	Percent of functionally limited elderly not using home delivered meals N=708	Percent of all elderly who do not use congregate meals N=2734	Percent of all elderly who do not use any food program N=2734
All	86.7	95.3	89.2	71.6
Any food insecurity	73.3	90.9	82.3	63.0
3+ food insecurities	68.2	94.8	66.1	47.6
Any functional limitations	81.0	95.3	86.1	75.6
3+ functional limitations	85.3	86.6	89.7	70.9
Low income	86.7	95.9	82.8	70.3
Very low income	81.4	95.4	82.9	65.8
Any eating-related illness	84.0	94.5	89.8	84.0
3 eating-related illnesses	76.4	95.8	86.4	80.0
Lives alone	88.1	95.7	82.6	77.5

While there are quite high levels of non-use of programs, there are higher rates of participation among those in need, than among the elderly population as a whole, indicating that the programs are appropriately targeted.

Reasons for Non-Participation

In addition to looking at the characteristics of those who appear eligible but do not use programs, we also examine why these individuals do not participate in the available programs. For all programs, in spite of the fact that these individuals appear to be in need of services and eligible for the programs, the reason given most often for non-use was related to ineligibility or perceived lack of need. Table 3 shows that:

- even among those in the lowest income category, 55 percent reported that they either don't need food stamps, they get too much money or they have too much in savings or assets,
- seventy-two percent of those in the moderate income category gave one of these reasons, and
- a very small percentage of persons in either income category gave other reasons for non-use.

Table 3. Reasons for Non-Use of Food Stamps (FS)

	Percent of all elderly	Percent of elderly who are very low income	Percent of elderly who are low income	Percent of elderly who are not low income
Don't need/ ineligible	73.9	55.2	71.9	77.9
Not comfortable applying for FS	7.1	14.1	10.1	5.2
Don't know where or how to apply	2.3	4.0	2.9	1.9
No transportation	0.4	1.7	0.7	0.1
The amount isn't worth the trouble	4.2	10.0	5.0	2.8
Not comfortable using FS	6.6	9.2	10.1	5.6
Other	3.1	6.4	4.8	2.2

Table 4 presents the reasons for non-use of home-delivered meals.

- 78 percent of those with one or more functional limitation reported that either they never needed home-delivered meals, they no longer needed them or that they had applied but were ineligible.
- Again, very small percentages of individuals with functional limitations gave any other reasons for non-use.

Table 4. Reasons for Non-Use of Home-Delivered Meals (HMD)

Reasons	Percent of All Elderly	Percent of Elderly with No Functional Limitations	Percent of Elderly with at Least One Functional Limitation
Don't need/Ineligible	87.1	90.0	78.1
Don't know where or how to get HDM	2.2	1.2	5.5
Not comfortable applying for HDM	2.0	1.9	2.3
Cost of meal too high	0.6	0.5	1.0
No space available	0.5	0.5	0.5
Other	4.6	3.0	9.6

As shown in Table 5, the story for congregate meals is very similar. The majority of our sample--over 70 percent--report that they do not need the program. And again much smaller percentages of individuals give any other reasons for non-use.

Table 5. Reasons for non-use of congregate meals (CM).

N=2734	Percent of all elderly
Don't need program	70.4
Don't know about program or where it is	4.2
Don't feel comfortable going	8.7
No space available	0.7
No transportation to program	3.5
Too many health problems	4.9
Cost too much	0.7
Other	10.2

Who Uses Food Assistance and Meal Programs?

Who among the elderly does use food stamps, home-delivered meals and congregate meals? 4.4 percent of our sample uses food stamps. Based on data from the Food and Nutrition Service and the Census Bureau it is estimated that 5.4 percent of elderly Americans used food stamps in the summer of 1990. 1.5 percent of the sample currently receives home-delivered meals and 10.8 percent currently attend congregate meals. We do not have comparable official estimates because our data is based on a sample 65 and older while official estimates are based on individuals aged 60 and older. According to calculations based on data from the Administration on Aging and the Census Bureau, 2 percent of Americans aged 60 and older receive home-delivered meals and 6.2 percent attend congregate meals.

We confine our analysis of who uses each program to those individuals, who by our approximation, are eligible for the program.

Food Stamps

Table 6 presents the bivariate relationships for the use of food stamps. As this table shows:

- individuals under 75 years old are more likely to use food stamps than those aged 85 or older,
- blacks are more likely than whites to use food stamps,
- individuals who live with their children are more likely to receive food stamps than those who live with a spouse,
- individuals with very low incomes are significantly more likely to use food stamps than those with moderately low incomes,
- welfare recipients are more likely to receive food stamps than nonrecipients,
- individuals who cannot drive are more likely to use food stamps than those who can drive, and
- individuals with a conditions that interferes with their eating and individuals with a condition that has made them change their diet are more likely to use food stamps than those without these problems.

Sex, residence in a metropolitan area, the existence of other functional limitations, or tooth or mouth problems and alcohol consumption have no affect on receipt of food stamps.

Table 6. Bivariate relationships between use of food stamps and independent variables.

N=754		% using food stamps
Low-income elderly		13.2
Age	65-74	16.5 R
	75-84	11.3
	85+	7.0*
Race	White	11.0 R
	Black	24.7*
	Other	10.2
Household composition	With spouse	11.0 R
	With child	26.5*
	With other relatives	15.9
	With nonrelatives	25.1
	Alone	11.9
Income	Very low	18.6*
	Moderately low	3.2 R
Welfare	Receives	49.7*
	Does not receive	7.8 R
Can drive	Yes	9.5 R
	No	19.6*
Condition interferes with eating	Yes	18.9 *
	No	12.1 R
Condition has changed diet	Yes	17.1 *
	No	11.7 R

* p<=0.05 compared with reference category,R.

Further multivariate analysis shows that eating related health problems do not affect food stamp use. It appears that the relatively high use of food stamp use among these individuals is not caused by the health problems themselves, but is the result of high rates of functional limitation among these individuals.

Multivariate analysis also shows that family structure also has no effect on food stamp use and that use of food stamps is high for persons living with their children because these families are substantially more likely to receive welfare than other family types.

Home Delivered Meals

Table 7 presents the bivariate relationships for the use of home-delivered meals. As this table shows:

- individuals age 75 and older are more likely to receive home-delivered meals than those 65-74,
- individuals living alone or with a child or non-relatives are more likely than those living with a spouse to receive home-delivered meals,
- individuals who cannot leave home without help, cannot shop or cannot prepare food without assistance are all more likely to receive home-delivered meals than those without these limitations,
- individuals with two functional limitations are more likely than those with only one limitation to receive home-delivered meals and those with three limitations are more likely to receive home-delivered meals than those with two limitations, and
- finally, individuals with a health condition that has changed their diet and individuals with a tooth or mouth problem are more likely to receive home-delivered meals than those without these problems.

Sex, race, residence in a metropolitan area, income and receipt of welfare have no affect on the receipt of home-delivered meals.

In multivariate analysis there is a significant difference in receipt of home-delivered meals for men and women that was not true at the bivariate level. Women are less likely to use home-delivered meals than men. It appears that it is women's living arrangements that explain this result. As both the bivariate and multivariate analysis show, the likelihood of receiving home-delivered meals is lower for those living with a spouse, than for those living alone or with nonrelatives. Women are substantially less likely than men to live with a spouse--14.6 percent versus 72.2 percent and are substantially more likely to live alone or with nonrelative--48.4 percent versus 12.2 percent. If women and men had the same living arrangements, women would be significantly less likely to receive home-delivered meals at the bivariate level as well.

Multivariate analysis also showed no significant age difference in the receipt of home-delivered meals, rather it appears that this age difference at the bivariate level can be explained by differences in level of functional limitations, living arrangements and eating and health related problems.

Table 7. Bivariate relationships between use of home-delivered meals and independent variables.

N=708		% using home-delivered meals
Elderly with 1+ functional limitations		4.7
Age	65-74	1.9 R
	75-84	6.4*
	85+	7.2*
Household composition	With spouse	0.6 R
	With child	7.5*
	With other relatives	4.0
	With nonrelatives	32.4*
	Alone	4.3*
Can leave home without help	Yes	0.7 R
	No	12.0*
Can shop without help	Yes	1.4 R
	No	11.7*
Can prepare food without help		
	Yes	3.7 R
	No	8.0*
Number of funcitional limitations		
	1	0.7 R
	2	3.8*
	3	14.7*
	4+	13.6*
Condition has changed diet	yes	8.4*
	no	2.6 R
Tooth or mouth problems	yes	7.9*
	no	3.8 R

* $p <= 0.05$ compared with reference category,R.

Congregate Meals

Table 8 presents the bivariate relationships for congregate meals. As the table shows:

- persons over 75 years old are more likely to attend congregate meals than those under 75,
- blacks are less likely to attend congregate meals than whites, while individual in the "other" racial category are more likely to attend congregate meals,
- women are more likely than men to attend congregate meals,
- persons living alone are more likely to attend congregate meals than those living with a spouse,
- people who live in nonmetropolitan areas are more likely to attend congregate meals than those in metropolitan areas,
- low-income individuals are more likely to use congregate meals than those who are not low-income,
- people who cannot drive are significantly more likely than those who can to attend congregate meals,
- individuals with at least one limitation are more likely to attend congregate meals than those with none, but this finding obscures the true relationship between number of limitations and congregate meal use. Individuals with exactly one limitation are more likely to attend congregate meals than those without limitations, but use among individuals with 2, 3, or 4 or more limitations does not differ significantly from use among individuals without limitations,
- individuals who report having an illness or condition that interferes with eating are more likely to attend congregate meals than individuals who do not report this problem, and
- individuals who report consuming 2 or more alcoholic drinks in the day before the survey are significantly less likely to attend congregate meals than those with lower alcohol intake.

The existence of other functional limitations and eating related problems do not affect use of congregate meals.

Table 8. Bivariate relationships between use of congregate meals and independent variables.

N=2734			% using congregate meals
All elderly			10.8
Age	65-74		8.3 R
	75-84		14.8 *
	85+		13.7 *
Race	White		10.9 R
	Black		7.1 *
	Other		19.9 *
Sex	Male		6.9 R
	Female		12.6 *
Household compostion	With spouse		6.5 R
	With child		7.0
	With other relatives	3.1	
	With nonrelatives	6.5	
	Alone		17.7 *
	Has help if sick	Yes	5.0
		No	16.0
In metropolitan area	Yes		8.5 R
	No		16.8 *
Income	Very low		17.1 *
	Moderately low		17.2 *
	Not low income		8.3 R
Can drive	Yes		9.6 R
	No		14.6*
Number of functional limitations			
	0		9.6 R
	1		15.7 *
	2		13.5
	3		9.3
	4+		11.2
Condition interferes with eating	Yes		14.0 *
	No		10.2 R
Number of alcoholic drinks	0-1		11.4 R
	2+		4.8 *

* p<=0.05 compared with reference category, R.

All variables found to have a significant relationship to use of congregate meals at the bivariate level were significant at the multivariate level as well, except being over 85 years old, being female and having very low income. However, being female and having a very low-income emerge as significant when interactions between variables are taken into account.
The multivariate analysis shows the relationships between the use of congregate meals and the independent variables to be much more complex than at the bivariate level. Part of this complexity may result from the dual goals of the congregate meals program. Congregate meals are meant to provide both food and company.

Reasons for Use of Meal Programs

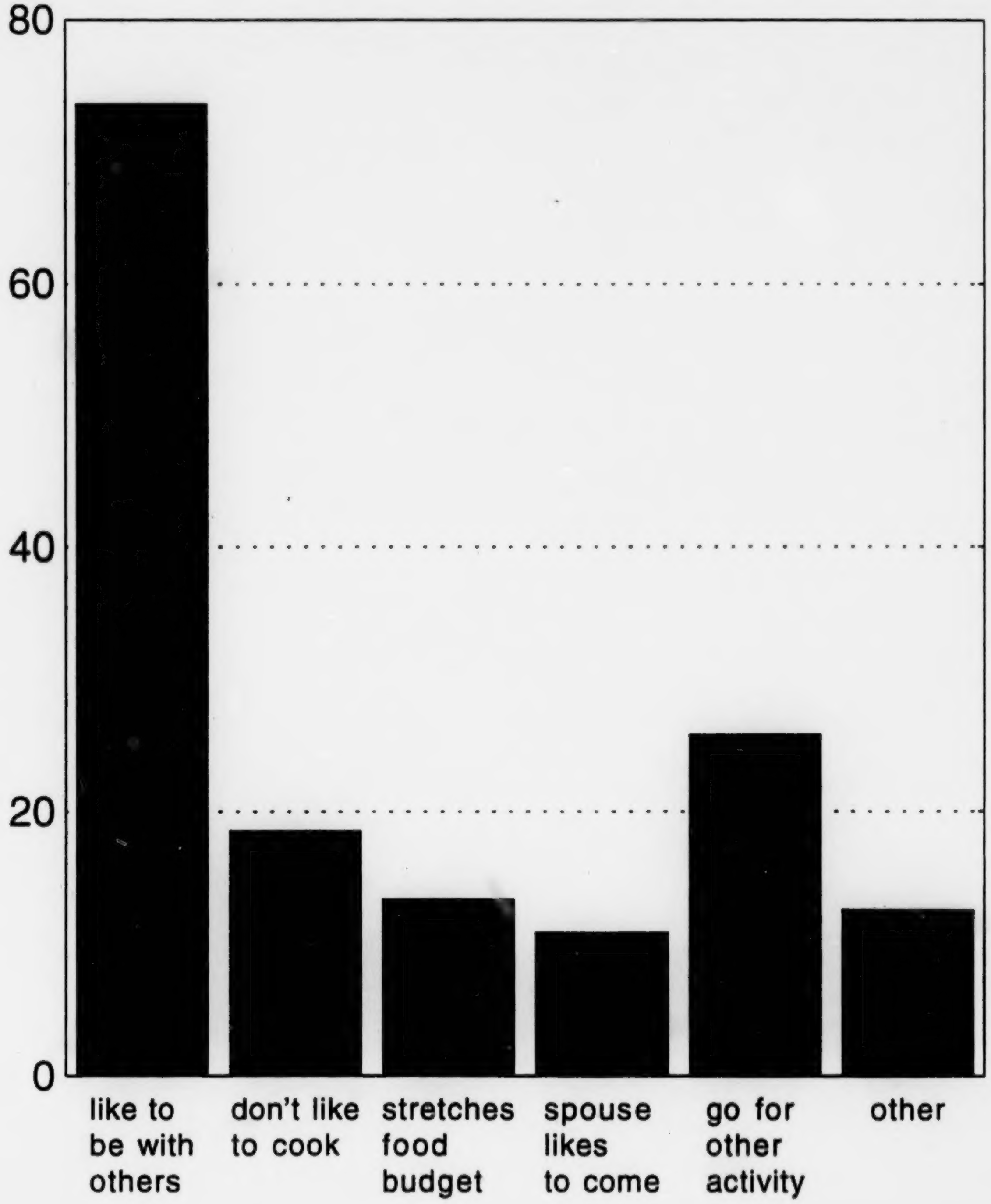
Congregate meals was the only program for which we asked respondents why they used the program. Figure 2 presents the distribution of responses given for use of congregate meals. Not surprisingly, the majority of the sample reports attending congregate meals because they like to be with other people. This is consistent with our analysis which showed that persons who live alone, persons living in nonmetropolitan areas, and persons who cannot drive are all more likely to attend congregatemeals than persons not in these situations. Living alone, in a nonmetropolitan area and being unable to drive may increase isolation and the need for socialization.

Summary and Conclusions

The data presented here suggest that hunger or food insecurity is a problem for many elderly Americans and more so for some subgroups than others. They also show very high rates of food insecurity among those who participate in food and meal programs. Overall, it appears that food assistance programs do a relatively good job of providing services for those who need them. As an individual's need for services from a food assistance program increases, her or his probability of receiving benefits from the program also increases.

However, when we look at absolute levels of program use among the needy elderly, we find large portions of those who have trouble getting adequate food and who appear to be eligible for food assistance programs, but do not receive benefits from these programs. Five out of eight elderly people who experienced food insecurity in the last six months currently receive no benefits from either food stamps, home-delivered meals or congregate meals.

Figure 2: Distribution of reason for attending congregate meal programs



Data Base Development and Results

Moderated by Dolores L. Torres
Texas Department of Protective and Regulatory Services

Five-Year History of Stages of Services in Child Protective Services

Texas Department of Protective and Regulatory Services

Jane G. Harrison
Jacob Esterline
Deborah Washington
Derek Williams

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Development and Analysis of a Statewide Historical Child Welfare Information System

Jane Harrison, Director of Statistics (Overview); Deborah Washington, Program Statistical Analyst (File Structure); Derek Williams, Program Statistical Analyst (File Creation); and Jacob Esterline, Research Specialist III, (Analysis), Texas Department of Protective and Regulatory Services, Management Services

Introduction

In 1989 The Texas Department of Human Services established the Resource Outcome Modeling Project (ROMP) to develop a vision for the Child Protective Services Program in Texas and to develop a management and budget methodology to associate resources with the most effective delivery of services. The major steps taken were to measure present work processes; profile current client programs, needs and outcomes; and to build a model which informs management about the impact of resource changes on outcomes for families and children. Objectives of the model were statewide consistency in service delivery, effective use of resources, developing methods of measuring performance, and providing the most effective response to client needs.

In order to consistently be able to measure needs, resource allocation and outcomes on a statewide basis it was decided that a unified statewide child welfare information system be developed comprised of information from existing child welfare, social services, foster care/adoption, and purchase of services systems used to gather data about and track abused or neglected children and their families in Texas. The resulting child welfare information system is referred to as the Service History File. It includes information as far back as 1978, with comprehensive matched client/case information beginning in 1984. The database is hierarchical and date-driven, with each change of status for a client child or parent producing an entry on the database. Current data evaluation is being made for the five year period from 1987 to 1991.

Construction of the database allows tracking of both the case as well as individual members of each case, as each individual has both associated case and client numbers. Historical progress of each client is associated with a level of status, with separate entries for each dated service change within each level of service. The levels of service in the Service History File are Investigations, Family Preservation, Temporary Care, Adoption, and Long Term Care.

In addition, variables differentiating living arrangement and placement types, legal status changes, as well as in-service recidivism are included. Secondary file components are available indicating purchase of service and demographic information.

The Service History File was constructed using several hardware and software systems. The source data systems are stored on a UNISYS mainframe. The mainframe data fields are stripped from source files using COBOL and output onto data tapes. The tapes are then installed on a personal computer connected to a Local Area Network, where the high speed FoxPro database software package is used to join the separate data systems using the specified level of service criteria. The output Service History File is then stored on both the LAN and the UNISYS mainframe. Checking, analysis and further file manipulation was conducted initially on the UNISYS mainframe using SPSS-X software. Current analysis continues using SAS software on a 486DX33 personal computer with LAN access.

Initial analysis of data from the Service History File focussed on yearly and five year averages for total service durations, foster care duration, adoptive care durations, average number of foster care placements, average number of adoptive placements, and recidivism rates, as well as regional geographic and demographic breakdowns. Resultant descriptive information has been included in data books for use by agency management and legislative staff.

Preliminary results of on-going analysis indicate an increase both in the number and duration of foster care placements over the five year period of the study. Overall length of service has also increased. Duration of case and number of placements per child was found to be greater in rural regions of the state than in urban regions.

Source Data for Service History

As currently designed, no existing system alone contains all data needed to provide a complete and comprehensive picture of Child Protective Services (CPS) involvement with clients relating to child abuse/neglect. Therefore, in order to provide management with information by which to measure both need and outcome, it was necessary to extract data from three existing systems merging this data into the integrated date base, Service History. The three systems used were Child Abuse/Neglect Reporting and Inquiry System, Social Services Management System/Foster Care, Adoption and Conservatorship Tracking System, and the Purchase of Service system.

The first step in accomplishing this task was to extract pertinent client data from each system developing several strip files with data being linked by both client and case identification numbers.

Child Abuse/Neglect Reporting and Inquiry System (CANRIS)

The CANRIS data base, developed in 1973, is an incident based on-line reporting and inquiry system which captures information related to the investigation of incidents of child abuse/neglect. Each record contains data relating to the investigation and all individuals associated with the abuse/neglect situation.

The information recorded on the CANRIS data base is divided into two sections: incident information and individual information.

The incident section contains data related to the incident i.e., date the abuse/neglect occurred, date the incident was reported to CPS, date the worker completed the investigation, disposition of the investigation, risk indicator, and priority at intake and end of investigation. This section also provides information on the worker conducting the investigation and if services are requested, the worker assigned for post-investigation services.

The person section of the data base contains identifying information on up to 20 individuals associated with the abuse/neglect incident. This area of the data base includes demographic data on each individual as well as types of maltreatment sustained by the victim or inflicted by the perpetrator, court action initiated, individual's role in the abuse/neglect situation, relationship to the oldest victim, and request for continuing services beyond investigation. Data is retained on the CANRIS data base for a period of six months to 18 years dependent on disposition and age of child.

Social Services Management System/Foster Care, Adoption, and Conservatorship Tracking System (SSMS/FACTS)

The SSMS/FACTS database is a client based system which provides data for all clients receiving services beyond investigation.

This system was developed in 1974 and is comprised of data on client demographics, eligibility status, and worker information relating to date services begin/end. The SSMS system was modified in 1980 to include data for FACTS which contains data on all children for whom the Texas Department of Protective and Regulatory Services (PRS) has been granted conservatorship. Data collected on these children include placement history, which track the number and type of placement, and legal status data. Both current and historical data is retained making it possible to provide complete information on services provided to clients.

Purchase of Services (POS)

The POS data base is a payment based system which was developed in 1976. It is used to capture information on services which the Department purchases for clients receiving on-going services. These purchased services include counseling, homemaker services, day care, psychological and developmental testing and evaluation, and parental training.

This system contains information on the number and type of services provided, cost per unit of services, and total amount paid for each service.

Data Extraction Procedure

Data Base Development and Results

To develop the files needed to build the Services History data base, the assigned client/case identification number of clients registered for on-going services on the SSMS/FACTS system were used as the driver to retrieve information from the CANRIS system. Data was also extracted from the CANRIS data base on individuals reported in abuse/neglect incidents where no on-going services were provided. Both files were then merged to provide a comprehensive picture of the investigation stage of service. The same process of using SSMS/FACTS as the driver was also used to extract data on purchases services from POS.

Source Files

The initial data extraction of client population data covered a time frame of five years and provided information for all clients receiving services on September 1, 1985 or later. If a client was receiving services on September 1, 1985, all previous service data was captured for as far back as the system files allowed. This information was used to develop eight files from the three systems. These eight files contain data on 1) client demographics, 2) direct delivery worker registration information, 3) conservatorship worker tracking information, 4) placement information, 5) legal status information, 6) purchase of services, 7) CANRIS incident information, and 8) CANRIS individual information.

Data Base Development and Results

SOURCE FILE DESCRIPTION

CLIENT DEMOGRAPHICS FILE

Case ID number
Client ID number
Record type
Sequence number
Client name
Date of birth
Sex
Ethnic group
Marital status
Date Opened for on-going services
Client characteristics
Street Address
City of Residence

DIRECT DELIVERY WORKER INFORMATION FILE

Case ID number
Client ID number
Record type
Sequence number
Worker ID number
Action code
Client type
Effective data for worker registration
Reason for closure

CONSERVATORSHIP WORKER INFORMATION FILE

Case ID number
Client ID number
Record type
Sequence number
Action code
Effective date for worker registration
Worker responsibility
Worker ID number

PLACEMENT INFORMATION FILE

Case ID number
Client ID number
Record type
Sequence number
Placement number
Date of placement
Facility ID number
Living arrangement
How provided
Permanency plan

LEGAL STATUS FILE

Case ID number
Client ID number
Record type
Sequence number
Legal status
Legal status date

PURCHASE OF SERVICE FILE

Case ID number
Client ID number
Record type
Sequence number
Type of service
Service date
Unit type
Unit quantity
Service amount

CANRIS INCIDENT INFORMATION FILE

Case ID number
Client ID number
Record type
Sequence number
Incident ID number
Date reported to PRS
Date worker completed investigation
Investigation worker ID number
Date abuse/neglect occurred
Priority at intake
Priority at end of investigation

CANRIS PERSON FILE

Case ID number
Client ID number
Record type
Sequence number
Incident ID number
Line number
Relation to oldest victim
Role in abuse/neglect situation
Type of maltreatment
County of Residence
Marital status
Legal action
Client characteristics
Request for on-going services

Creation of the Service History File Database

The Service History file is an attempt to interpret eight distinct files. These files contain valuable information about Child Protective Services clients, but even if the files were presented in a unified form, it would still be very difficult to follow. The Service History file is such a unified form, but with some additional computational features for better comprehension and smoother flow than that of the separate files. By applying some predefined tables, protocols, and good judgements during the construction of the file, normally difficult and impossible situations have been overcome, producing a file that can be used in many different ways.

One of the main difficulties in producing a file such as the Service History file are the tools of construction. Since the original files were produced by the MIS department using a COBOL on a Unisys mainframe, the first thought was to continue with that process. This proved to be quite difficult and cumbersome. With the growing power of PC's, however, and a very fast dBASE-compatible database application called FoxPro, it was decided to move the project over to that platform.

So the first step in the process was to download the files from the mainframe onto the PC. These files were then imported into dBASE-compatible databases, which are also readable by FoxPro. The TYPE field and the SEQUENCE field were removed from each database, and a new field, ORDER, was added. This field is filled with a Sorting ID used to help in sorting the Service History database when key dates are the same, and it maintains proper order of the records.

The first step in understanding the Service History construction is to realize that the database does not make any sense until it makes it through all the steps. Information is continuously being interpreted and processed up until the last moment, so certain reasons for construction are not obvious until the completion. The beginning databases are nothing but lists of records. The Service History database starts that way also, but at the end, presents a pretty good picture of clients as they progress through the system.

Both the Registration database and the Tracking database have dates which show when a client enters the system and leaves the system. These dates, usually called "OPENing" and "CLOSEing" date, occur on different records and must be matched in order to find the beginning and end of those services. The way that this is done is through a three phase process. The first phase is to find an exact match. By matching records using a key containing the CASE number, the CLIENT number, and worker ID (called BJN) identification, "OPENs" are matched with the nearest unmatched "CLOSE" record. The second phase loosens the matching key by removing the BJN ID and attempts a second match. And the final phase just uses the left over "OPEN" records because it is possible for the databases to contain ongoing cases with no "CLOSEing" record. All the matching records will then have both an "OPENing" and "CLOSEing" date after this process, with the exception of the third phase records, which have blank "CLOSEing" dates.

The CANRIS case database contains information about each incident of abuse and/or neglect and the CANRIS client database has information about each individual clients. These databases are merged together using a Natural Join process using the CASE number and the INCIDENT id. This is done by taking each records from the CANRIS case database and distributing it among all the matching clients from that particular case.

The next step is to produce a PLACEMENT/LEGAL database. This database is constructed by appending three databases together. A new field, START for starting date, is added in the PLACEMENT/LEGAL database. Activity dates from each type of database are copied into a START date field and then sorted by that field. This forms a history of placement and legal status changes in date order. By using a complex merging and lagging algorithm, the records are merged and condensed so that each Placement information has Legal information and each Legal information has Placement information on a single record. These records are sequentially numbered to maintain correct sorting order. Records from the already matched Tracking database are used to provide breaking points to show TDPRS termination of responsibility.

A Pre-Service History database can now be formed by appending all the records produced by the last three steps into a single database, which contains fields from all the other databases. The trick to the whole process is good sorting. Activity dates are copied into the START field, and then the database is sorted. This sort puts the database into a history format. The task of turning a Pre-Service History database into a Finished Service History database is accomplished by running a few more computational procedures to make a more logical and readable format for analytical uses.

The STAGE field in the database is used to represent a temporary classification of a Service Period for our clients. The first computation is to assign fixed stage identifications of "2" for the CANRIS records, "3" for the Registration records, and "4" for the Tracking records. A pre-defined matrix of Placement data and Legal data are used to compute the stage for the PLACEMENT/LEGAL records, which are numbered "4" through "7". On the second pass, logic is then used to produce the most proper flow of stage definitions.

The period of each record of the Service History database can overlap, and this must be corrected. There are pre-defined rules for this overlapping, and correcting them can cause records to have their durations grow or shrink, and in some cases disappear entirely. I have found that records should never be deleted because you may need them again, and in the case of the Service History database, they would be very difficult to replace. Instead, a zero or negative duration record would be flagged with a minus in the STAGE field, and should just be skipped.

The next step in computation is to carry as much of the information from previous records into current one. This provides a full aggregate of previous data and to enhance linear progression of analysis by other staff members.

Due to the completeness of the Service History database, many different files can be created from it. One of the databases we have created is called the Condensed Service History file. This file is created by removing the flagged records and collapsing multiple Stage durations into single durations. This procedure provides even more readability and can be used to demonstrate Stage Progression patterns among our clients.

Service History File Analysis

The Service History File when presented for analysis actually consists of 3 separate component: (1) the Service History File itself, consisting of all classification information records presented in date order by case and client; (2) the Demographic File, consisting of all demographic information gathered about all clients to which case and client number have been attached; and (3) the Purchase of Services File, consisting of all purchased service records to which case and client number have been attached. In order to perform analysis on issues involving demographics or purchased services, the appropriate companion file must be matched up and joined to the Service History File.

When conducting file operations involving demographics or purchased services, all Service History File manipulation involving particular record categories is first accomplished before the match-up. For example, after all information on each adoption client is distilled down to a single client record for analysis, that record is then matched and joined with the demographic record for that record in the Demographic File, using the case and client numbers as the match criteria. This saves limited hard disk space by not duplicating demographic information on each and every record on the Service History File (SHF), there being as many as 132 records for any one client on the SHF.

Resources used for file manipulation and analysis consist primarily of SAS and later SAS/Windows software run on a 486DX33 Personal Computer with 8MB of RAM and 660MB SCSI hard drive, with additional hard drive storage available on a Local Area Network. Due to its size (currently 180 MB), the full Service History File is kept on the LAN. This allows sufficient operating space on the PC hard drive to run required programs, in particular, sort routines. Sort routines typically require about three times as much in available storage as the source file. There is not sufficient operating hard drive room on the LAN to run these programs. A condensed version of the SHF is kept on the PC hard drive, the condensed file merging all contiguous records of a given stage classification into a single encompassing record. Typically, all inquiries into questions involving specific records, such as number of individual placements, are run against the full SHF on the LAN. Most other inquiries are run against the condensed SHF (currently about 100 MB) kept on the PC. The Demographic File is kept on the PC in compacted form, being expanded when needed to append demographic records to SHF distilled records. The Purchase of Services file is made available on LAN drives as needed, there not being sufficient hard drive storage available on either PC or LAN to keep it continually available.

As indicated earlier, the Service History File consists of a date ordered sequence of service classifications for each client.

Stages of Service

Stage 1 — Intake

Intake begins with the receipt of a written or verbal report of abuse or neglect. It includes receiving the report, checking TDPRS records, notifying law enforcement, discussing the report with the supervisor, determining whether abuse/neglect allegations are involved, determining the urgency of response, and making referrals to other resources. This stage also includes tasks needed to transfer intake information when another worker will conduct the investigation and completion of all appropriate documentation. It ends with the decision that a referral will or will not be investigated.

Stage 2 — Initial Assessment/Investigation

Initial Assessment/Investigation begins with the decision that a report will be investigated. It includes formal or informal risk assessment processes, provision of services during the investigation, and completion of appropriate documentation to close or transfer the investigated case. It ends with the determination of whether a report is founded or unfounded, whether there is a risk of maltreatment, and whether further protective services are needed.

Stage 3 — Family Preservation

Family Preservation In-home (No Placement) begins with the decision to open a case for ongoing services when the initial assessment/investigation indicates a risk of maltreatment and a determination that the child's safety can be assured in the family's home. It includes ongoing services provided to reduce the risk of abuse/neglect. This stage ends when services are terminated or any child is removed to substitute care.

Stage 4 — Temporary Out-of-Home

This stage begins with a court action giving legal responsibility to TDPRS.
Child Placed by Department into Temporary Substitute Care (4-A) — Actual placement of the child in substitute care (including placement with relatives if the Department has conservatorship) by the Texas Department of Protective and Regulatory Services. It includes services to the child and to the family toward reunification; it also includes work with the foster family, substitute care provider, or compensated and uncompensated relatives providing substitute care. It ends when the child is returned home, parental rights have been terminated or when a permanency plan other than return home has been determined.

Child Voluntarily Placed by Family into Temporary Substitute Care (4-B). With Relative or Other Non-TDPRS Facility. This stage begins with the actual placement of a child in substitute care by the family. This stage includes services to the child and to the family toward reunification. It also includes work with the foster family or substitute care provider. It ends when all children are returned home or when parental rights have been terminated. This stage excludes placements made by TDPRS when the Department has petitioned or plans to petition the court for conservatorship of a child.

Stage 5 — Family Reunification

Child in Own Home-Post Placement (5-A). This stage begins when the child is returned home from temporary substitute care. It includes services to the child and the family to stabilize the return, reduce the risk to the child, and prevent future removal. It ends when the Department's conservatorship and services have been terminated or if the child is removed from the home for a second time.

Child Placed with Relatives-Post-Placement (5-B). This stage applies when a placement with a relative is intended to be the child's permanent placement. It begins when the child is placed with relatives after being in temporary substitute care. It includes services to the child and the family to stabilize the return, reduce the risk to the child, and prevent future removal. It ends when services are terminated or the child is removed from the home.

Stage 6 — Plan is Adoption

Substitute Care-Adoption is Plan begins when parental rights are terminated. It includes work with the foster family and child, adoption placement activities, adoptive supervision with the adoptive family and child, and adoption subsidy program activities. It ends when the adoption is consummated or the permanency plan changes to an option other than adoption.

Stage 7 — Long-Term Sub Care

Long-Term Substitute Care begins when a permanency plan other than reunification or adoption is determined. Parental rights may or may not be terminated. It includes work with the child, parents, and foster family or substitute care provider. It ends when the permanency plan changes to an option other than long-term substitute care or when the child is no longer TDPRS's legal responsibility.

Stage 8 — Court Ordered Social Services and Out-of-Town Inquiries (OTIs)

Court Ordered Social Study is an assessment of a person's past and present level of functioning as a parent or caretaker. The court may appoint TDPRS to prepare a social study in any suit affecting the parent-child relationship if TDPRS is a party to the suit or has an interest in the suit.

Out-of-Town Inquiries are requests for information or services that TDPRS either receives or initiates. OTIs come from public and private social-service agencies, including TDPRS child protective services units, from individuals, and from courts. A request is considered an OTI if it is from an area that is not served by the local CPS unit.

Analysis of each stage of service involves:

(1) Calculating a duration for each stage, the duration periods ranging from days for Investigations to months for Placement durations and recidivism;
(2) Calculating total number and average number of placements for stage involving Temporary Care, Adoptive Placement, and Long Term Care;
(3) Determining rates of Recidivism - Recidivism is here defined as either
    (a) A new incident of Abuse/Neglect and/or return to care after closure of a case, or
    (b) A new incident of Abuse/Neglect while case open for services, or
    (c) Return to placement while case open for services in Family Reunification;
(4) Determining Demographics for selected placement categories.
(5) Determining the type and amount of services purchased during each stage.

The principle method of file manipulation involves extensive use of lagged variables. Since records are arranged chronologically, it is possible to lag onto the last record for each case or client any date or other variables which is necessary to perform any analysis. With SAS it is also possible to lag down with a conditional cumulative function for any numeric variable to get conditional placement counts or cumulative time durations. For example, a one line distilled record can be constructed for each client experiencing adoption consummation which includes and/or totals each and every placement in substitute care, temporary care, and adoption, as well as dates pertaining to each placement. This adoption subfile can then be matched with the Demographics File and the Purchase of Services File to build a comprehensive, compact file with easily accessible information on any issue involving adoption.

Summary of Results:

Results are currently published annually using a five year average for each statistic, using data from the most current five fiscal years. Data cited here is from the Fiscal Years 1987 to 1991. An earlier publication included data from parts of Fiscal Year 1985 through part of Fiscal Year 1990. Analysis is currently beginning on a file inclusive of Fiscal Years 1988 through 1992. In Texas the fiscal year goes from September 1 through August of the following year. Thus Fiscal Year 1992 runs from September 1, 1991 through August 31, 1992. Review of the Service History File shows data to be mostly reliable from 1987 onward, and fully reliable from 1988 onward. Use of the five year average gives a general statistic less subject to annual fluctuations, especially for regional data. Selected statistics are presented below in Stage of Service order.

STAGE 2 - Investigations: The 5 year average statewide duration of an investigation is 16.9 days for an investigation opening for any service. This breaks down further to 28.8 days for an investigation opening into Family Preservation and 5.5 days for investigations resulting in removal to Temporary Care. For those cases not opening until a second subsequent investigation, 48% experienced the subsequent opening investigation within 6 months for Family Preservation, and 51% within 6 months for Temporary Care.

STAGE 3 - Family Preservation/In-Home Services: The 5 year average duration of Family Preservation Services for a client is 7.7 months. However, this statistic is an underestimate of the expected annual figure in that the annual average has increased each year from 6.8 months in FY87 to 8.6 months in FY91. I would thus use the 8.6 month figure for any statewide projections.Similarly I would not use the FY91 statewide average for regional predictions as the range is from a low of 6.5 months in one region to a high of 12.4 months in another. The 6.5 month region has shown little variation over the 5 year span, but the 12.4 month region has increased each year since FY88.

The 5 year recidivism rate for cases closed after Family Preservation is 19.2% statewide, with a range of 15.8% to 25% for different regions of the state. The 5 year rate for recurrence of Abuse/Neglect while open for service is 11.7%, with a range of 9.2% to 18.7% in different regions of the state. Of interest is that the region of the state with the highest recidivism rate while open has one of the lowest rates of recidivism after closure. This is the same region with the high FY91 duration of 12.4 months.

STAGE 4 - Temporary Out-of-Home Care: A review of durations of service by episode indicates a five year average of 9.6 months for each episode of Temporary Care followed by and closing in either Family Reunification, Adoption, and Long Term Substitute Care. However, here again there has been an increase every year from

8.1 months in FY87 to 10.8 months in FY91. The regional averages range from a low of 7.1 months to a high of 11.6 months for the 5 year average.

STAGE 5 - Family Reunification following placement: The statewide 5 year average for time in Temporary Care for cases closing in Family Reunification is 8.9 months. This is further broken down by whether the child is returned to its original home (6.9 months) or to a relatives home (12.6 months). The 5 year total time in care average for children returned and closing in Family Reunification is 16.7 months, including time back in the home under State supervision prior to legal case closure. The five year return-to-home rate for children removed in temporary care is 59.2%. Of those returned home, 55% are returned home within 6 months of removal, with 26% in temporary care for more than 12 months prior to return home.

STAGE 6 - Adoption: The statewide 5 year average for total time in service from first removal in Temporary Care to Consummation in Adoption is 33.6 months. This is further broken down into 17.2 months in Temporary Care prior to termination of parental rights, 8 months waiting for adoptive placement, and 8.4 months in adoptive placement prior to consummation. Of children consummated in adoption, 53% had 3 or fewer total placements and 28% had 5 or more total placements (inclusive of Temporary Care, Substitute Care, and Adoptive placement). Differences exist between urban and rural regions for both duration and number of placements. For example, average duration of temporary care is 15.7 months in Urban regions compared to 20.9 months in the Rural regions of the state. Average number of Temporary Care placements are 2.6 in Urban regions and 3.0 in Rural regions of the state. The most extensive look at demographics to date has been done with consummated adoptions. Findings indicate that 48% of all consummated adoptions involve children from a sibling group. Siblings make up 55% of children with at least one unsuccessful placement prior to consummation. Children described as emotionally disturbed constitute 7% of all consummated adoptions, and 11% of children with at least one unsuccessful placement prior to consummation. Female children make up 52% of consummations, and 53% of children with at least one unsuccessful placement prior to consummation. Ethnic makeup of successful consummations is 55% white, 17% black, 24% hispanic and 3% other. 77.4% of adopted children are between the ages of 1 and 9 at consummation.

Summary Review:

The intent of this presentation has been to describe the creation and use of the Service History File by the Texas Department of Protective and Regulatory Services, with emphasis on process. The Service History File is an integration of 8 Child Protective Service Data Files into one uniform data source for tracking and studying child protective services, with sub-files available for looking at demographics and purchased services. A description of the source files has been provided, together with the software, programming and technology utilized to develop the Service History File. The File, which is updated at least annually, provides data used for resource allocation and budget planning, as well as general information. Sample statistics indicating file use were discussed to indicate the information currently being drawn from the file.

The Service History File continues to evolve, with new data fields being added as time and resources permit. It is expected that as additional years of data are added to the file it will be possible to view trends with increased accuracy. Current results indicate increases in duration of Temporary Care, as well as Total Service Time for Family Reunification, Long Term Substitute Care and Adoption. Early review of a new file inclusive of FY92 data shows this trend to be continuing. As data from FY88 onward seems fully reliable, a shift in emphasis from ensuring full reliability of data to full analysis and utilization of data is taking place. In particular, changes in Recidivism over time and relationships between Purchased Services and outcomes will be studied.

In conclusion, the Service History File creation and the analysis of its data has provided a method to statistically evaluate a service delivery system (in this case, of child protective services in Texas), to provide client outcome data, and to provide the source data for the Resource Outcome and Budget Model. It is hoped that this description of the work done so far will benefit those in the field working on similar projects that evaluate service delivery systems, whatever the service or program.

Health Reform

Moderated by John Cosby
Kentucky Legislative Research Commission

The Difficulties in Moving Individuals and Families on Medicaid into Self Sufficiency - Leonard J. Kirschner, M.D., M.P.H., Director, Health Care Initiative, EDS (Electronic Data Systems)

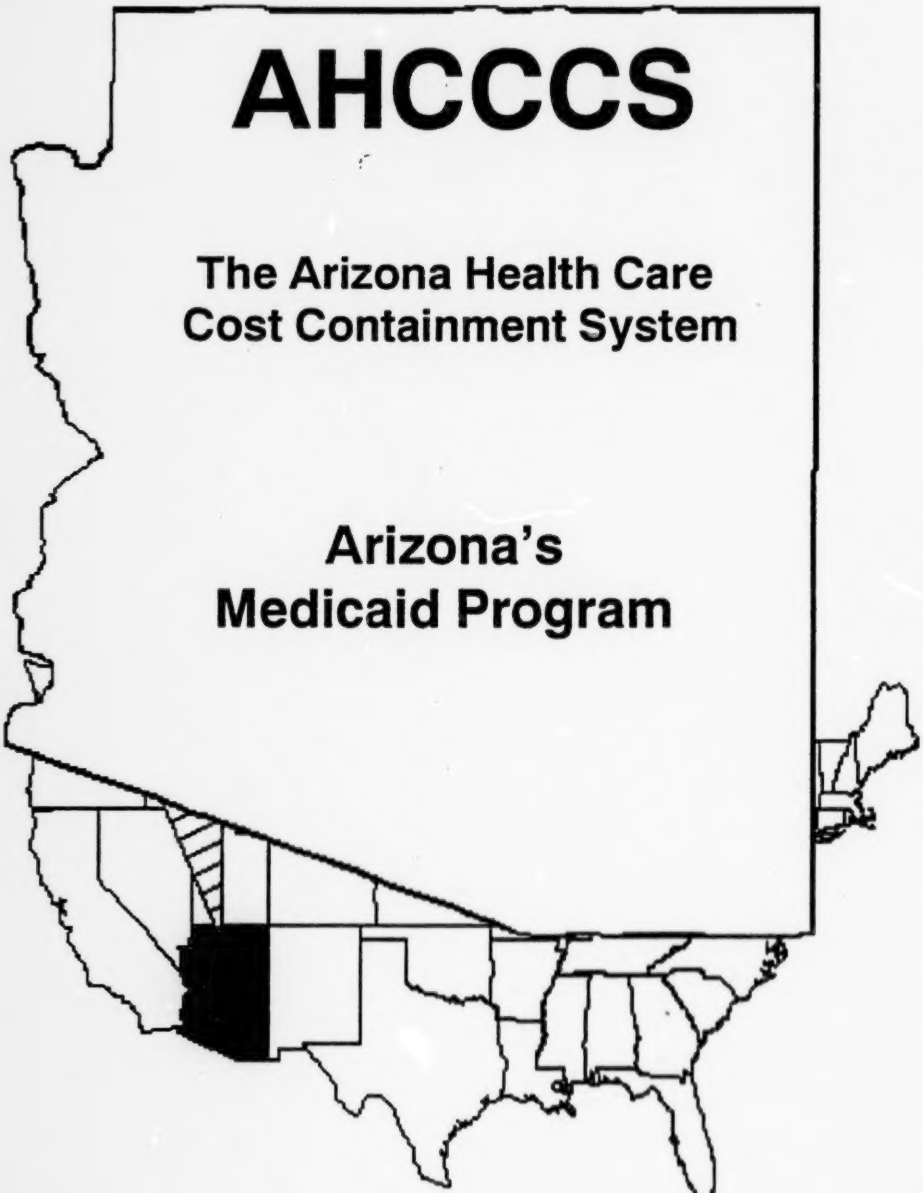
Health Care Reform Overview: Federal and State Issues - Jeffrey Sanders, Vice President, Health Systems Management, PCS Health Systems, Inc. [Oral presentation only]

Health Care Utilization by Children Entering Foster Care: Factors Associated with Provider-Initiated Health Referral and Referral Completion - Christina Risley-Curtiss, M.S.S.W., Ph.D., Assistant Professor, Arizona State University of Social Work

BEST COPY AVAILABLE

National Association for Welfare Research and Statistics

Scottsdale, Arizona
August 11, 1993



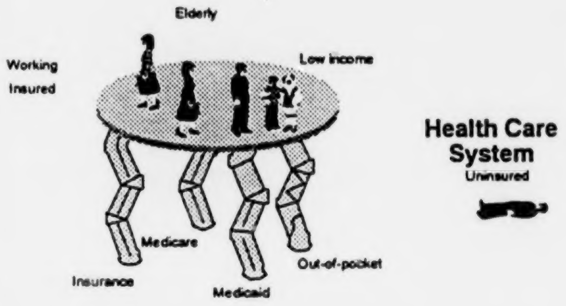
AHCCCS

The Arizona Health Care Cost Containment System

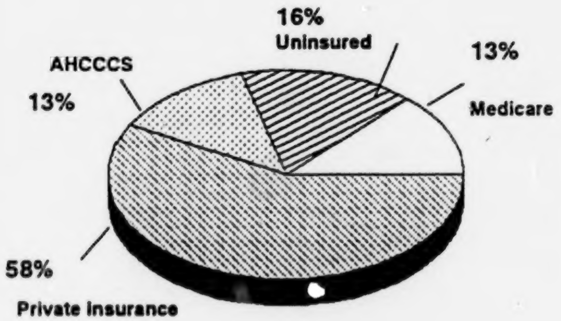
Arizona's Medicaid Program

Leonard J. Kirschner, M.D., M.P.H.

Health Care in the United States - 1993


Elderly
Working
Insured
Low income
Health Care
System
Uninsured
Medicare
Insurance
Medicaid
Out-of-pocket

Health Care Coverage in Arizona — 1993



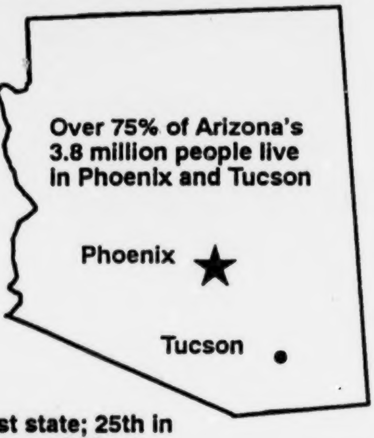
Total Population 3.8 million

Indigent Health Care Prior to AHCCCS

- 14 Counties with Different Eligibility and Income Criteria
- 14 Counties Each Performing Their Own Eligibility
- 14 Counties with Different
- Service Delivery Systems
- Some Counties on Verge of Bankruptcy

Rural issues and AHCCCS

Arizona's demographic profile

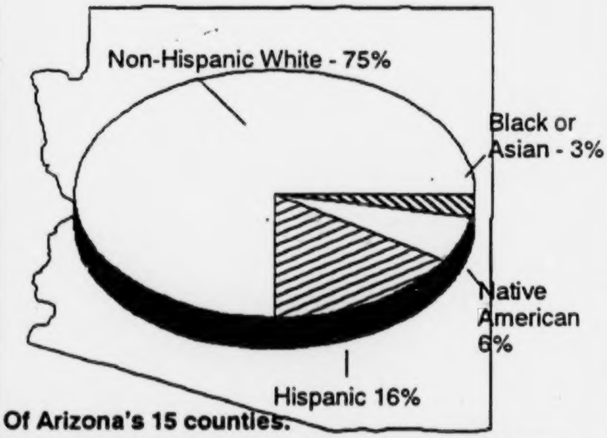


Over 75% of Arizona's 3.8 million people live in Phoenix and Tucson
Phoenix
Tucson

6th largest state; 25th in total U.S. population

Less than 1/5 of land in Arizona is privately owned, the rest being federal, state or Indian reservations

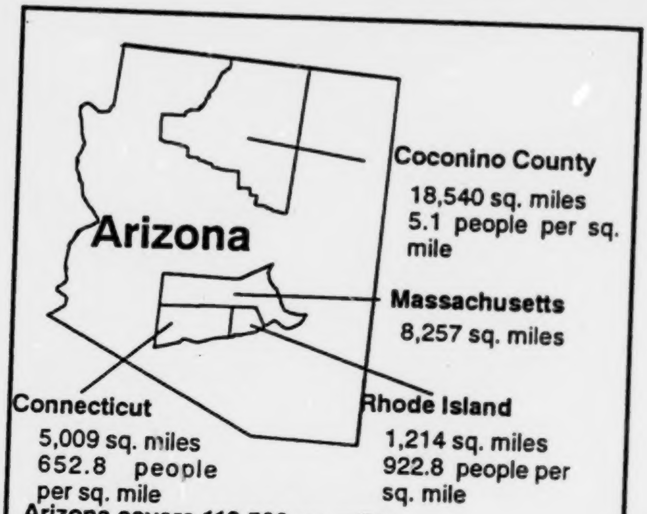
Arizona's demographic profile



Of Arizona's 15 counties:

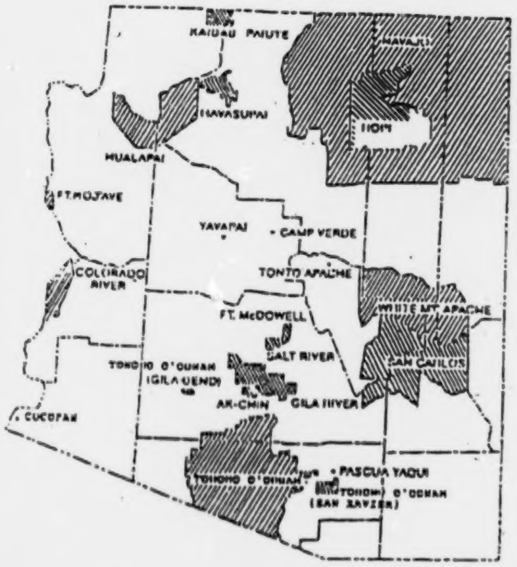
- **6 are frontier (populaton densities of less than 7 people per square mile)**
- **1 is near-frontier (density 7.8)**
- **6 are rural**

Insurance coverage: approximately 26% of Arizona's population are on Medicare or AHCCCS; 16% are uninsured for medical care

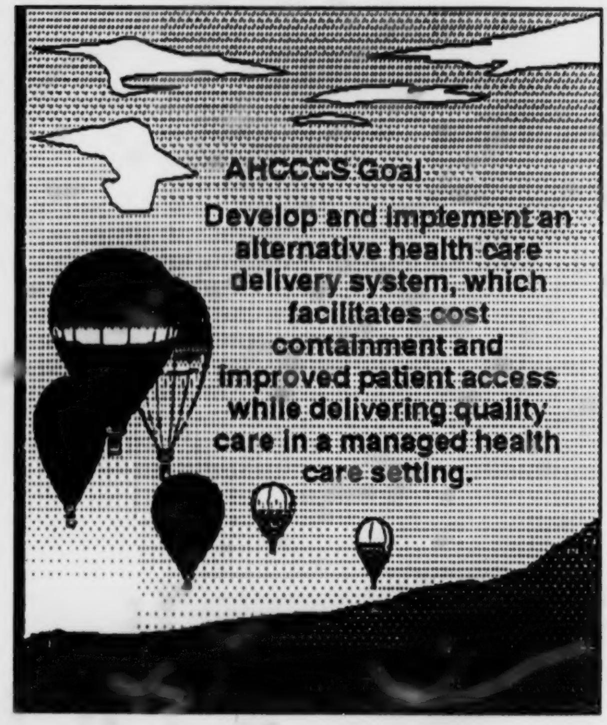

Arizona
Coconino County
18,540 sq. miles
5.1 people per sq. mile
Massachusetts
8,257 sq. miles
Connecticut
5,009 sq. miles
652.8 people per sq. mile
Rhode Island
1,214 sq. miles
922.8 people per sq. mile

Arizona covers 113,500 sq. miles.

Coconino County, AZ, covers 18,540 sq. miles as ompared with the three states of Rhode Island, Connecticut and Massachusetts, which together cover only 14,480 sq. miles.


KAIBAB PAIUTE
NAVAJO
HAVASUPAI
HOPI
HUALAPAI
FT. MOJAVE
YAVAPAI
CAMP VERDE
COLORADO RIVER
TONTO APACHE
FT. McDOWELL
WHITE MT. APACHE
SALT RIVER
SAN CARLOS
TOHONO O'ODHAM (GILA BEND)
AK-CHIN
GILA RIVER
COCOPAH
TOHONO O'ODHAM
PASCUA YAQUI
TOHONO O'ODHAM (SAN XAVIER)

There are 20 Indian reservations in Arizona. These reservations comprise approximately 25% of the state's land area.



AHCCCS Goal

Develop and implement an alternative health care delivery system, which facilitates cost containment and improved patient access while delivering quality care in a managed health care setting.

AHCCCS Objectives

- Competitive bidding of prepaid capitated contracts
- Development of a primary care physician "gate keeper" network
- Co-payments to control utilization
- Restriction on freedom of choice by members as a cost containment mechanism

1115 Waivers granted July 13, 1982

1. Exclude SNF
2. Exclude eyeglasses, dental and hearing aids as part of EPSDT
3. Exclude home health
4. Exclude family planning
5. Exclude nurse midwife service
6. Enable cost sharing (co-payments)
7. Exempt well baby from cost sharing
8. Limit mental health services
9. Restrict freedom of choice
10. Exclude costs prior to October 1, 1982
11. Flexibility in reimbursement
12. Enable county funds to be used for match
13. Advisory panel in lieu of medical care advisory committee
14. Guaranteed enrollment of health plans up to 6 months

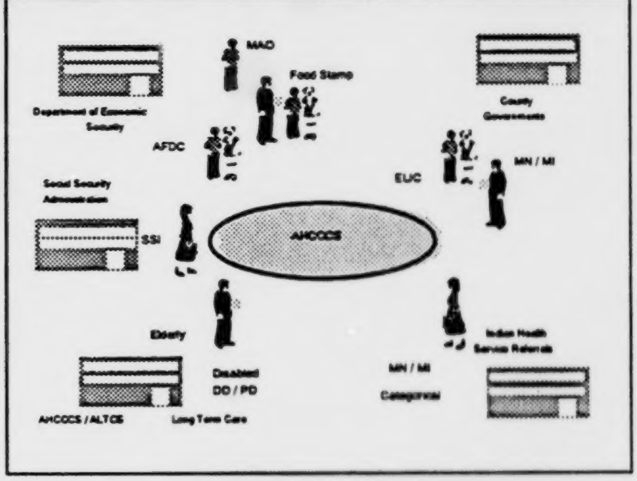
Current 1115 Waivers
1993

1. Mandatory enrollment
2. One year lock-in
3. Six month guarantee
4. Flexibility in Financing
5. Actuarially determined rates
6. No Fee-for-Service Limit
7. 75/25 rule
8. One plan in rural areas

Start-up problems — 1982

- Short start-up
- Systems
- Prepaid health plans
- Private administrator
- Limited state staffing and experience
- Eligibility / enrollment

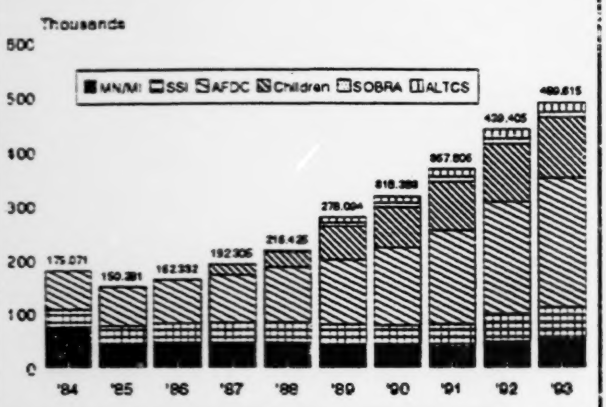
AHCCCS Eligibility


MAO
Food Stamp
Department of Economic Security
County Governments
AFDC
EUC
MN / MI
Social Security Administration
SSI
AHCCCS
Elderly
Indian Health Service Referrals
Disabled DD / PD
MN / MI
Categorical
AHCCCS / ALTCS
Long Term Care

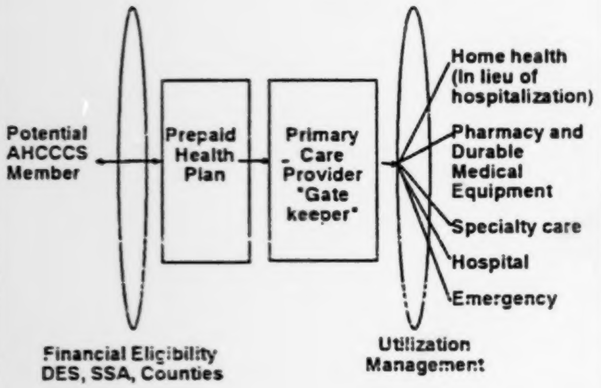
Annual Income by Household Size 1993

	AFDC	Medically Needy	Food Stamp	Federal Poverty Level (FPL)	140% (FPL) SOBRA
1	$2,448	$3,200	$ 6,816	$ 6,970	$9,758
2	$3,300	$4,266	$ 9,192	$9,1430	$13,202
3	$4,164	$4,810	$11,580	$11,890	$16,646
4	$5,016	$5,354	$13,956	$14,350	$20,090
5	$5,868	$5,898	$16,332	$16,810	$23,534

AHCCCS enrollment as of July 1 each year



Acute Care Prepaid Model


Potential AHCCCS Member
Prepaid Health Plan
Primary Care Provider "Gate keeper"
Home health (In lieu of hospitalization)
Pharmacy and Durable Medical Equipment
Specialty care
Hospital
Emergency
Financial Eligibility DES, SSA, Counties
Utilization Management

AHCCCS Funding

SFY 1994

Federal	Counties/Other	State
$960,921,400	$189,493,400	$477,191,800

TOTAL
$1,627,606,600
↓
AHCCCS
↓
Prepaid Health Plan
or
Providers
↓
Service to Members

The Clinton Plan

Employer Contributions

Employee Contributions

Government Subsidies

Regional Health Alliance
(Governed by employers and consumers)

HMOs

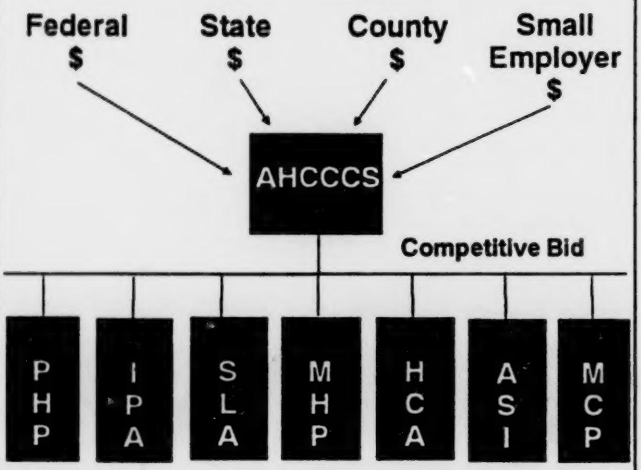
Insurance companies

Doctor/Hospital networks

Other plans

A Functioning HIPC

Maricopa County, Arizona



Federal $

State $

County $

Small Employer $

AHCCCS

Competitive Bid

PHP

IPA

SLA

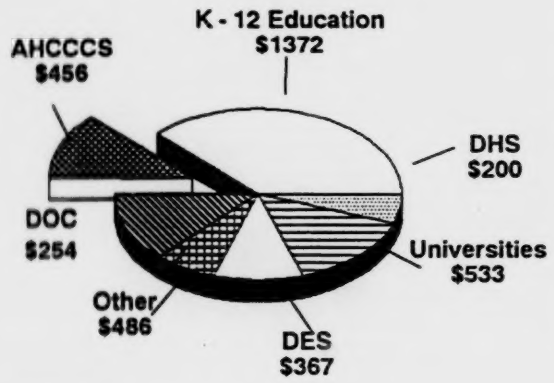
MHP

HCA

ASI

MCP

Where Appropriated Dollars Go
FY1993



Total $3,668

FINANCIAL MONITORING

- Audits
    - Annual CPA audit
    - Annual AHCCCS review by CPA
    - Audits and inspections by AHCCCS
- Financial Reporting
    - Audit guide
    - Working capital ratio
    - Equity per enrollee
    - Medical costs as % of capitation
    - Admin. costs as % of capitation
    - Days claims outstanding
- Ownership and Related Party Transactions
- Performance Bonds
- Sanctioning Authority
- ALTCS
    - Uniform reporting
    - Annual audit

QUALITY ASSURANCE

- AHCCCS Medical Director's Association
- Plan QA Committee
- Annual QA Study
  - C-section rates
  - E.R. use
  - Diabetes follow-up
  - Circumcision beyond neonatal period
  - Poly-pharmacy
- Annual AAACH Audit
  - Low back pain
  - Hypertension
  - EPSDT
  - Otitis media
  - Provider site evaluation
- Ombudsman
- Grievance and Appeals

CAPITATION

- Rate Codes

  AFDCSSI-Medicare MN/MI-Med. Children
  SSI-w/o Med. MN/MI w/o Med.

- Competitive Bids
  - Fourteen plans
  - Fifteen counties
- Capitation Rates

  Medical care
  - Utilization
  - Unit cost
  - Copayments

  Administration

  Deductions
  - TPL
  - Medicare
  - Reinsurance
  - Deferred liability

Sample Maricopa County Capitation Rates 1993

Category	PMPM
AFDC	114.99
SSI - Medicare	104.77
W/O Med.	295.99
MN/MI - Medicare	136.52
W/O Med.	264.84
Children	83.87

AHCCCS PRESENT

A national model for cost effective delivery of quality health care

A five way partnership

- Federal Government - HCFA
- State of Arizona
- Arizona counties
- Prepaid plans
- AHCCCS members

416

Health Care Systems

Cost

Patient Satisfaction

Quality

Utilization

Accessibility

SRI International Evaluation of AHCCCS

January 1989

Summary of Findings

Cost: Over the program's first five years, the average per capita costs for AHCCCS increased at a rate of 23.1 percent while those for traditional Medicaid increased 37.3 percent.

Utilization: Hospital utilization under AHCCCS was lower than traditional Medicaid and indicated a significant savings.

Quality of care: Care for children under AHCCCS was in greater conformance with generally accepted guidelines from the American Association of Pediatrics.

Access and satisfaction: Even though beneficiaries reported some problems with access to emergency care, access to routine care was better under AHCCCS and absolute satisfaction levels were high.

In addition,...AHCCCS "probably does more than any other state Medicaid program" in the area of quality assurance.

Laguna Research Associates

Evaluation of AHCCCS

When compared to average expenditures in 20 fee-for-service states

From FY '83 to FY '91

	AHCCCS	FFS
Average per capita increase	69.2	113.3
Average Annual per capita cost increase	6.8	9.9

Laguna Research Associaties

Evaluation of AHCCCS 1993

When compared to expenditures in 20 fee-for-service states, AHCCCS saved

	FY '90	FY '91
Dollars in millions	16.0	51.5
Percent	5.8%	13.2%

A Flinn Foundation Report

Findings

AHCCCS in 1989:
A Progress Report

Utilization of services

The Harris data indicate that AHCCCS has successfully substituted ambulatory care for care inappropriately provided in emergency rooms.

FISCAL YEAR 1993

U.S. BUDGET

Coordinated care and State Medicaid programs

"Arizona was the last state to join the Medicaid program and as a result may be the most progressive. Rather than running a Medicaid program similar to other states, Arizona has run the program since its inception as a coordinated care operation."

HEALTH CARE IN THE 21ST CENTURY

Aids

Aging

Alzheimer's

Addiction

Abuse

HEALTH CARE ISSUES

Medically Necessary Services

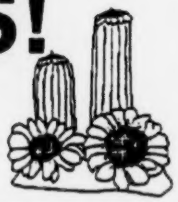
Spiraling Costs

On Reservation

Rural Services

Medicaid and Budgeting

AHCCCS WORKS!



Health Care Reform Overview: Federal and State Issues

Jeffrey Sanders, PCS Health Systems, Inc.

This presentation provided a current overview of health care reform, compared federal vs. state issues on health care reform and discussed the implications of moving individuals and families toward self-sufficiency with health coverage.

Health Care Utilization by Children Entering Foster Care: Factors Associated with Provider-Initiated Health Referral and Referral Completion

Christina Risley-Curtiss, M.S.S.W., Ph.D., Arizona State University School of Social Work

Abstract

Because of the events that precipitate entry into foster care, of social characteristics, and of the trauma associated with placement, foster children represent one of America's most vulnerable groups in terms of their health needs. Unfortunately, prior research has demonstrated that the probability of the health needs of these children being met is poor. Additionally, the Maryland Department of Human Resources has been sued for, among other things, failure to provide adequate health care to foster children. The resulting consent decree requires that children entering foster care receive a health assessment within five days of entry and a more comprehensive assessment after 30 days.

The primary purpose of this study was to determine the ability of selected factors to explain 1) provider-initiated health referrals, and 2) the completion of those referrals for a cohort of children entering foster care in Baltimore. Multivariate analyses techniques were used with data from nonprobability samples of 1,910 children entering care (#1) and 229 children in care for at least 30 days (#2).

Consistent with previous studies, this study found that the sample children had multiple health problems. More than 70 percent of the children had two or more problems, and 98.4 percent of the children had at least one referral for additional services. Moreover, the children continue to have unmet health needs with only 45 percent of non-routine referrals completed during the study period. Age, race, sexual abuse, number of mental health problems, number of physical health problems and sexual activity explained 39 percent of the variance in number of referrals while age and completion time explained 9 percent of the variance in referral completion. Age was the best predictor of both number of referrals and referral completion. Age and number of mental health problems predicted type of referral (dental, medical or mental health).

The Problem

At the end of 1990 there were an estimated 407,000 children in foster care in the United States (Tatara, 1991). Nationally approximately 75% of children placed in foster care are there primarily because of abuse, neglect, or abandonment (U.S. Department of Health and Human Services, 1988). Thus, because of circumstances precipitating placement into foster care (e.g., maltreatment), and of social characteristics such as poverty, children coming into care are at high risk for medical and psychosocial problems (see e.g., Jenkins & Norman, 1969; Kinard, 1980; Mouzakitis, 1984; Sauber, 1967). In addition, many children come into care out of crisis situations and may soon experience changes in workers and placement. Any ongoing health care they may have had is interrupted. Therefore, although placement in foster care, i.e., removal from the home, is intended to be a therapeutic intervention, it also may contribute to a child's poor health (Eisenberg, 1962; Fine, 1989; Schor, 1988).

Given these circumstances, foster children represent one of America's most vulnerable groups in terms of their emotional, mental, and physical health needs. Previous research has clearly demonstrated that foster childre are unhealthy (see e.g., Gruber, 1978; Hochstadt et al., 1987; Kavaler & Swire, 1983; Schor, 1982; Shah, 1972). However, the probability of their comprehensive health needs being met, in the past, has been small, with medical and mental health services to foster children often duplicated, inefficient, and fragmentary (see e.g., Halfon & Klee, 1987; Moffat, Peddie, Stulginskas, Pless & Steinmeitz, 1985: Schor, 1982; Shah, 1974). A number of researchers (Benedict, White, Stallings & Cornely, 1988; Halfon & Klee, 1987; Shah, 1972; Schor, 1988; Steinhauer, 1988; Kavaler & Swire, 1983; White, Benedict, & Jaffe, 1987) have suggested that low utilization of health services by foster children may reflect such factors as health policy, the health delivery system, the foster care system, and individual characteristics of foster children and their families. Little research, however, has been done to address specific factors and how they may contribute to utilization patterns of foster children.

The primary purpose of this study was (1) to determine the ability of selected child and family characteristics to explain the number of provider-initiated referrals for a cohort of children entering foster care in Baltimore, Maryland (Objective 1); (2) to describe the health referral completion status of a subsample of this same population (Objective 2); and (3) to determine the ability of selected child, family and agency factors to explain the completion (or lack of completion) of those health service referrals (Objective 3).

Theoretical Framework/Model

The Aday/Andersen (1975) model of access to health care was used to guide the current study. The model conceptualizes health services utilization to be a function of four factors: health policy, health services delivery characteristics, consumer satisfaction, and population characteristics. Factors may affect health care utilization directly or, indirectly, through one or more of the other factors. For example, the health delivery system may affect utilization patterns directly (e.g., centralized vs. decentralized delivery models), or it may have an impact on utilization indirectly by affecting the characteristics of the popultaion-at-risk through, for instance, public health education.

One of model's strengths is that it suggests a number of points at which investigation and intervention can be directed; it provides a framework for thinking about ways to improve the health care of foster children. However, application of the Aday/Andersen model to foster children requires reconceptualization of certain relationships. For example, since foster children are wards of the state, Combs-Orme et al. (1991) suggest the inclusion of the child welfare system as another system that may affect access to health care. Not only do foster children experience the limitations of the health care system for low-income children, but they also are affected by deficiencies within the child welfare system itself.

Setting

The study site was the Baltimore Foster Care Health Project (FCHP) which operated from April, 1989 through June, 1991. The FCHP was a direct result of the original L.J. v. Massinga consent decree which mandated that: (a) all foster children should have an initial health care screening, preferably prior to placement, but no later than 24 hours following placement (Level I); and (b) all foster children should be referred for a comprehensive health assessment within 30 days of entering placement (Level II). The assessment should be completed within 60 days of entry (L.J. v. Massinga, 1988).

Methods

Sample

The primary sample, used to address Objective 1, consisted of 1,910 foster children who entered foster care (included all types of foster care except kinship care) between April, 1989 and May, 1991. A nonprobability convenience sample of 291 children who received a Level II screening was used to address Objective 2 and a subsample of 229 children was used to address Objective 3.

Data Collection Techniques

The data were collected principally from two forms; a preplacement exam form (PPE) that was completed by the nurse practitioners who conducted the examinations, and a referral completion form developed specifically for the study. The information on the PPE was obtained from the preplacement exam and from interviews with Child Protective Service Workers, and the child, if appropriate.

The second form was designed to collect the referral completion data. These data were collected at the Level II assessment visit from medical records, interviews with the foster parents and/or caseworker, and medical personnel if needed.

Study Variables and Analyses

Study variables were selected on the basis of theory and research findings, and the availability of data. Hierarchial ordinary least squares multiple regression was used to analyze the data. All statistical tests were nondirectional with an alpha of .05.

Objective 1. The total number of referrals recommended for each child was regressed on three blocks of independent variables (demographics, reasons for placement, and current health status) containing a total 13 variables (Table 1). "Number of referrals" was a continuous level variable (range 0-9) that referred to the number of follow-up services recommended for each child at the preplacement exam. The order of entry for the variable blocks was determined by the chronological order of variable occurrence. Stepwise regression was used for entry of independent variables within each block.

Objective 3. The same was done for Objective 3 with two exceptions. Due to a smaller sample size, the seven reasons for placement were collapsed into three variables: (1) maltreatment only (physical abuse, sexual abuse, neglect and abandonment); (2) child's need only (parental absence or incapacity, child's needs, and child's behavior); and (3) both maltreatment and need. In addition, a fourth block of six agency-related variables was entered last (total independent variables = 16). The dependent variable was "proportion of need met" (PONM). PONM was a continuous level variable, calculated by dividing the number of urgent and non-routine referrals completed by the day of the child's Level II assessment by the total number of such referrals a child had from his or her PPE exam. The date of the Level II assessment was used because this was the date that information on preplacement referral completion was gathered.

Results

Descriptive Analyses

The results of the descriptive analyses indicate that the 1,910 children were predominantly African- American (83.9%) with an even division between boys and girls and a mean age of approximately 7 years (6.96, s.d. = 5.18). Fifty per cent of the children were age six or younger.

Neglect was the most common reason for placement (49.7%), followed by parental absence or incapacity (28.2%), a reason for placement that is closely related to neglect (in some states it would not be considered apart from neglect). Physical abuse was the third most common reason for entry (26.3%), followed by abandonment (21.7%), child's behavior (13.2%), sexual abuse (6.2%), and child's need (4.4%). Since up to three reasons for placement were coded for each child, the categories are not mutually exclusive. Of the 1,910 children, 55.7% had only one identified reason for entry, while 38.8% had two reasons and 5.4% had three reasons (mean= 1.5; s.d. = .6).

With regard to health status, approximately 91% of the sample had at least one physical problem and the majority of the children had more than one problem identified (mean= 2.62; s.d. = 1.71); 58.3% had 2 to 4 problems, and another 13.5% had 5 to 10 problems. In addition, 59.2% of the children had at least one mental health problem identified (mean= 1.06; s.d. = 1.17), with 30.1% having two or more.

The lower prevalence of mental health problems as compared to physical health problems was due, in part, to age. For example, in this study the mental health measure included the presence or absence of suicidal and homicidal ideation. In very young children who were pre-verbal such ideation could not be measured.

The final health status variable, sexual activity, was generally coded "inapplicable" when a child was too young for the question of sexual activity to be considered appropriate: 64.1% of this sample. Of the 686 children to whom the question was asked, 42.1% reported being sexually active.

Finally, approximately 98% of the children had referrals for additional services with almost 75% referred for two or more services (mean=2.4; s.d.= 1.3). The most common type of follow-up service recommended was medical (91.7)%; however, the greatest need for urgent follow-up was in the mental health area.

Objective 1 Anaylsis

The overall model (Table 2) was statistically significant and accounted for almost 39% of the variance in number of referrals a child received ($p \leq .0001$). Variables from all three blocks entered the model, with 6 of the 13 independent variables selected for entry: age, race, sexual abuse, number of mental health problems, number of physical health problems and sexual activity.

Age and race explained 34% of the variance and both were positively associated with number of referrals. Thus, children who were older and/or white (coded 1) had, on the average, more referrals. Age entered first with an adjusted R^2 of .34. Independent of age, race accounted for a very small but statistically significant .3% of the variance.

Of the seven reasons for placement only suspicion of sexual abuse met the criteria for entry. While the amount of independent variance added was again very small (<1%), the positive relationship indicates that children who were placed because of suspected sexual abuse, independent of race and age, had more referrals than children placed for other reasons.

All three health status variables were selected for entry and all were statistically significant in a positive direction. Together, they explained approximately 4% of the variance in number of referrals, over and above the other variables already in the model.

In summary, approximately 39% of the variance in total number of referrals was explained by a subset of six independent variables. Age explained the largest proportion of the variance and made the strongest contribution to predicting number of referrals (Beta = .55), controlling for all of the other 12 variables. Number of mental health problems made the second strongest relative contribution (Beta = .20). In contrast, number of physical health problems made a very small contribution (Beta=.06). Thus, age and mental health were the best predictors of the number of referrals for additional services.

Objective 2. The results of these descriptive analyses indicate that the 291 children on whom referral completion data were gathered were similar to the primary sample of 1,910. In relation to the agency-related variables (Table 3), the majority of the children had their Level II assessments within 90 days of their preplacement exam (mean = 80), and had not been moved (75.9%) or had a change of worker between assessments (75.3%). At the time of the Level II assessment most of the children were placed in some form of foster family home (71%) and had workers who were female (82.1%) and/or African-American (76.6%).

When referrals for additional services were made they were ranked by immediacy of need: urgent, non-routine, routine. It would be expected that more urgent referrals would be completed during the study period than non-routine or routine referrals, and that more non-routine referrals would be completed than routine. The data supported this expectation (Table 4) with an overall .61 completion rate for urgent referrals, .39 for non-routine referrals, and .28 for routine referrals. The rate of completion for urgent and non-routine referrals combined was .45. These rates indicate that almost 40% of urgent referrals and more than 60% of non-routine referrals were not completed during the time between Level I and II assessment. Put another way, approximately 33% of the children had no urgent/non-routine referrals completed while another 33.7% had all urgent/routine referrals completed. Roughly 60% of the sample had 50% or less of their referrals completed.

Completion rates also were calculated for specific providers (Table 5). Urgent and non-routine referrals for a sexual abuse evaluation (.69) or to a medical provider (.56) had the highest rates of completion while such referrals for reproductive (.36) and dental services (.37) had the lowest. Given the lack of health care that many of these children have had in the past, and that there was an urgent or, at least non-routine need for these services, all of the completion rates are low. Consistent with the literature on health service utilization by children and, of particular concern, is the low rate of completions for mental health and dental referrals.

In summary, the findings of these analyses are consistent with the literature, which suggests that many of the health care needs of foster children are not being met. Overall, fewer than 50% of the urgent and non-routine referrals were completed with one-third of the urgent referrals and 60% of the non-routine referrals not completed.

Objective 3. The overall model (Table 6) was statistically significant accounting for approximately 9% of the variance in proportion of need met ($p \leq .0001$). Only two variables, each from a different block, entered the model: age and completion time (amount of time between the preplacement exam and the second level assessment).

Age accounted for 6% of the variance and was negatively related to proportion of need met. Thus younger children had, on the average, a higher proportion of their needs met than did older children. None of the variables in the second (reasons for placement) or third (health status) blocks of variables added significantly to the amount of variance accounted for, hence, none were entered into the model. Finally, of the six agency-related variables only completion time was selected for entry and it accounted for an additional 3% of the variance in proportion of need met, above and beyond that accounted for by age. The relationship was in a positive direction so, after controlling for age, the longer the completion time, the higher the proportion of need met. Change of worker, worker race or gender, current placement, and number of places were not statistically significant.

The above regression analysis tested for main effects. Because of the possibility of interactions occurring between variables, three interactions were tested with the more parsimonious model identified above: worker race X child's race, worker gender X child's gender, and total number of referrals X completion time. None of the interactions tested were significant at the $p \leq .05$ level.

In summary, 9% of the variance in proportion of need met was explained by a subset of two of the original 16 variables: age and completion time. Age accounted for the largest portion of the variance and was the strongest predictor of utilization with younger children having, on the average, higher proportions of their health needs met. In addition, as might be predicted, the more time there was to complete referrals, the higher the proportion of need was met.

Limitations

As with all studies, this one has limitations that must be taken into consideration when interpreting its results. These limitations include the following: (1) some of the children in the samples may have already been examined and treated for some health problems prior to being examined by the FCHP thus underrepresenting some types of health problems; (2) the health variables were coded as aggregates rather than condition-specific which limits interpretation of the data and may have washed out some differences; (3) the use of BCDSS definitions of maltreatment limits the external validity of the study; (4) the reasons for entry into care were "suspected," not substantiated, so any effects of maltreatment must be interpreted with caution; and (5) inter-rater reliabilities for a few of the variables were sligthly below .5 (.5 or above was considered acceptable using the Kappa statistic).

In addition there three potential problems with the regression model for Objective 3: (1) the finding that the completion time variable had several outliers, (2) the loss of power to detect significant effects due to reducing the sample size from 291 to 229, and (3) the influence of the agency-related variables. It was initially believed that the agency-related variables would have considerable influence on the dependent variable. If this were so, it might have increased power to have entered them into the equation earlier, for example, as the first block. These problems were addressed by conducting four additional regression analyses. The results of all four analyses supported the original model with the same two variables selected for entry and similar proportions of variance accounted for.

Discussion of Results

The results of this study clearly support past research that indicates foster children have a high provider-defined need level and are poor utilizers of health care services, especially dental and mental health services (e.g., Dubowitz et al., 1990; Kavaler & Swire, 1983; Moffat et al., 1985; Schor, 1982; Simms, 1989). The data also suggest that children with more needs (older children) get fewer services than children with less need (younger children). This is especially discouraging since these data were collected more recently than other studies, the children were involved in a new health project designed to improve their health care, and the agency that had custody of them was under a federal consent decree that specifically required the provision of adequate health care.

In addition, the descriptive findings are consistent with previous demographic studies of children in foster care which indicate that African-American children are over-represented in the foster care population and that neglect is the most common form of maltreatment (Kadushin & Martin, 1988); and with recent trends that indicate an increase in the number of younger children coming into care. Moreover, the demographics of Baltimore support the over-representation conclusion since children "other than white" constitute only about 68% of Baltimore's child population (Office of Research, 1990), as compared to 85% in this sample.

One of the most important findings was that neither gender nor race affected health service use. This was encouraging and, according to Aday and Andersen (1975), as it should be. However, it also was somewhat surprising, especially in regards to race. Previous research on children has consistently suggested that whites have higher health care utilization than non-whites (e.g., Benedict, et al., 1988; Horwitz, Morgenstern, & Berkman, 1985; Newacheck & Halfon, 1986; Rosenbach, 1989).

The study, however, did find other significant effects for race on health care referral and utilization. For example, while race was not significant in the final model for predicting total number of referrals, closer examination of the results showed that it was significant until health status variables were entered. Thus, what initially appeared to be an effect of race was really an effect of health status, i.e., differences in health status rather than race were causing the variance in number of total referrals. Since the bivariate correlations between race and two of the three health status measures were statistically significant, there is a need to look further at the health status of white children versus children in the "other" group. It may be that while health status is a better predictor than race of number of referrals, race is an important predictor of health status.

Furthermore, additional analyses suggested that white children were more likely than other children to have urgent and non-routine referrals. Examination of the data revealed no significant differences between whites and non-whites in number of physical health problems. However, there was a significant difference in number of recognized mental health problems, with white children having more problems than non-white children. In particular, they were more likely to admit having past or present suicidal ideation and to be reported as having behavior problems.

One explanation is, simply, that since white children had more mental health problems they were referred for mental health services more often. Mental health referrals were almost always urgent or non-routine since there is no expectation that periodic routine mental health screenings be done (e.g., in contrast to vision and hearing screens). The question then becomes, why were white children assessed as having more problems? One possible reason is that the white children in this sample were actually worse off psychosocially than the non-white children. For example, the white children were more likely to have a past history of sexual abuse, which often leads to psychosocial problems.

The study results did not support a hypothesized relationship between reason for placement and health need. Only suspicion of sexual abuse contributed to predicting need and none of the seven reasons were good predictors of utilization. The overall lack of effect was surprising and may be due to the probability that being maltreated, in general, increases the need for all services so that there is not a lot of variance in need by specific type of maltreatment. It also may be an artifact of the study measures. For example, although a large number of children entered care for more than one reason this was not taken into account in this study (e.g., testing interactions). In addition, because some of the individual types of maltreatment may have been under-reported their apparent effect may have been reduced.

Health status also was expected to be directly associated with need (i.e., health status would predict illness level measured as number of referrals) and health need was expected to affect utilization. The results of this study indicate that when considered as a single construct, health status was a significant predictor of number of referrals (i.e., need), but not of utilization. However, the lack of significant effect is not totally inconsistent with findings from some of the studies on children in general. For example, Newacheck and Halfon (1986) found that health status was a better predictor of volume of utilization than of use versus no use. In addition, much of the effect on health need was due to variation in the different dimensions of health status. For example, while all of the health status variables contributed to predicting total number of referrals, number of mental health problems clearly was the strongest predictor.

Finally, agency-related variables were assumed to be related to the use of health services. However, only "amount of time to complete the referral" predicted utilization. While it came as no surprise that the more time there was to comply with referrals the more utilization there was, the lack of effect for the other variables was unexpected. Although the agency variables used certainly did not measure all aspects of the agency situation, it was believed that they would have a significant impact on health service use.

The tests done in this study were primarily for main effects and are certainly not definitive. Nonetheless, they do support the notion that the application of knowledge gained from research on children in their own homes is not directly transferrable to children in out-of-home placements. Thus, there is a need to explore other dimensions of the variables used in both this study and in studies on children in general, and to examine new factors that may be unique to the situation of the child entering foster care.

However, to facilitate additional research, and to improve practice, it is imperative that foster care agencies develop automated tracking systems for health services. For instance, BCDSS had begun to implement such a system when the FCHP closed. Referrals were entered into a computer and monthly reports that listed these referrals were issued to supervisors. Unfortunately however, workers were not required to enter information on referral completion. If referral completion information was entered, and included reasons for failure to complete (e.g., no resource available), the computer could generate lists of children with both completed and uncompleted referrals, the type of uncompleted referral, and reasons for non-completion. If done on a regular basis, this information could help inform practitioners, policy makers, and researchers.

In conclusion, this study has added to our knowledge, yet research on health care use by foster children is still in its infancy. The process of explicating factors that may be related to health need and utilization has only just begun. The findings of this study, along with the findings of those who replicate this work and expand on it, can suggest areas for intervention in the process of health care delivery to foster children.

REFERENCES

Aday, L.A., & Anderson, R. (1975). Access to medical care. Ann Arbor, Michigan: Health Administration Press.

Benedict, M.I., White, R.B., Stallings, R., & Cornely, D.A. (1988). Racial differences in health care utilization among children foster care. Children and Youth Services Review, 11(4), 285-297.

Combs-Orme, T., Chernoff, R., & Kager, V. (1991).Utilization of health care by foster children: Application of a theoretical model. Children and Youth Services Review, 13, 113-129.

Dubowitz, H., Feigelman, S., Tepper, V., Sawyer, R., & Davidson, N. (1990). The physical and mental health and educational status of children placed with relatives: Final report. Baltimore, MD: University of Maryland Medical School, Department of Pediatrics.

Eisenberg, L. (1962). The sins of the fathers: Urban decay and social pathology. American Journal of Orthopsychiatry, 32, 5-17.

Fine, P. (1989). The emotional functioning of children in the foster care system. American Psychological Association Division 37 Newsletter, 12(3), 5,19.

Gruber, A.R. (1978). Children in foster care: destitute,neglected,... betrayed. New York: Human Sciences Press.

Halfon N., & Klee, L. (1987). Health services for California's foster children: Current practices and policy recommendations. Pediatrics, 80(2), 183-191.

Hochstadt, N.J., Jaudes, P.K., Zimo, D.A., & Schachter, J. (1987). The medical and psychosocial needs of children entering foster care. Child Abuse and Neglect, 1, 53-62.

Jenkins, S., & Norman, E. (1969). Families of children in foster care. Children, 16, 155-159.

Kadushin, A., & Martin, J.A. (1988). Child welfare services (4th ed.). New York: MacMillan.

Kavaler, F., & Swire, M.R. (1983). Foster-child health care. Massachusetts: Lexington Books.

Kinard, E.M. (1980). Mental health needs of abused children. Child Welfare, 59, 451-462.

L.J. v. Massinga, 838 F.2d 118 (4th Cir.1988).

Moffatt, M.E.K., Peddie, M., Stulginskas, J., Pless, I.B., & Steinmeitz, N. (1985). Health care delivery to foster children: A study. Health and Social Work, 10, 129-137.

Mouzakitis, C.M. (1984). Characteristics of abused adolescents and guidelines for intervention. Child Welfare, 63, 149-157.

Newacheck, P.W., & Halfon, N. (1986). The association between mother's and children's use of physician services. Medical Care, 24, 30-38.

Office of Research. (1990). Maryland statistical abstract: 1988-1989. Annapolis, MD. Maryland Department of Economic and Employment Development.

Rosenbach, M.L. (1989). The impact of medicaid on physician use by low-income children. American Journal of Public Health. 79, 1220-1226. Association of Social Workers.

Sauber, M. (1967). Preplacement situations of families: Data for planning services. Child Welfare, 46, 443-449.

Schor, E.L. (1982). The foster care system and health status of foster children. Pediatrics, 69, 521-528.

Schor, E.L. (1988). Foster care. The Pediatrics Clinics of North America, 35, 1241-1252.

Shah, C.P. (1972). The value of admission medical in child welfare. Ontario Association of Children's Aid Societies Journal, 15, 8-12.

Shah, C.P. (1974). Health services in child welfare agencies: An integrated approach. Canadian Journal of Public Health, 65, 34-36.

Simms, M.D. (1989). The foster care clinic: A community program to identify treatment needs of children in foster care. Journal of Developmental and Behavioral Pediatrics, 10(3), 121-128.

Steinhauer, P.D. (1988). The preventive utilization of foster care. Canadian Journal of Psychiatry, 33, 459-467.

Tatara, T. (1991, May). Child substitute care flow data for

FY 90 and child substitute care population trends since FY 86 (revised estimates). VCIS Research Notes, (3), 1-4.

U.S. Department of Health and Human Services.(1988). Child welfare statistical facts book: 1985: Substitute care(Ordering no. 105-86-8110). Washington, DC: Maximus,Inc.

White, R.B., Benedict, M.I., & Jaffe, S.M. (1987). Foster care health supervision policy. Child Welfare, 66, 387-398.

Table 1: INDEPENDENT VARIABLES

VARIABLE NAME	ABBREVIATIONS	CATEGORIES/DESCRIPTION
BLOCK 1: DEMOGRAPHICS		
Child's Age	Age	Chronological age at time of entry
Child's Race	Race	White/Other
Child's Gender	Gender	Male/Female
BLOCK 2: REASONS FOR PLACEMENT		
Physical Abuse	Physical Abuse	Each reason for placement was dichotomized into yes/no variables. Up to three reasons were recorded.
Sexual Abuse	Sexual Abuse	
Neglect	Neglect	
Child's Behavior	Behavior	
Child's Need	Need	Child's need was recorded when the child entered care because of the need for residential care or due to risk as a result of another child being abused.
Parental Absence or Incapacity	Parental Absence/incapacity	Parent was absent due to being in drug treatment, a psychiatric facility, etc.
Abandonment	Abandonment	Parent (s) abandoned child.
BLOCK 3: CURRENT HEALTH STATUS*		
Number of Physical Health Problems	Physical Health	The number of physical health problems identified.
Sexual Activity	Sexual Activity	Was the child sexually active? Categorized as yes, no, or inapplicable. A child was considered inapplicable if they were too young for the question to be relevant.
Number of Mental Health Problems	Mental Health	Number of mental health problems identified
BLOCK 4: AGENCY-RELATED VARIABLES**		
Number of Places	Number of Places	The number of places a child had been in since coming into this placement.
Completion Time	Completion Time	Amount of time the worker had to complete a referral.
Gender of the Worker	Worker Gender	Male/Female
Race of the Worker	Worker Race	White/African-American
Worker Change	Worker Change	Was there was a change in child's worker between assessments (yes/no).
Type of Placement	Placement Type	A multicategorical variable; the type of placement the child was in at the time of the Level II assessment.

* For Objective 3 analysis the dependent variable "number of referrals" was also included in the health status block of independent variables.

** Block #4 was used in the analysis of Objective #3 only.

Table 2: Level I Regression Model: Prediction of Number of Referrals (N=1910)

Blocks of Variables	R	Adjusted R^2	R^2 Change (df)	F Change
1. DEMOGRAPHICS Age Race	.58*	.34	.34 (2,1907)	490.19*
2. PLACEMENT REASONS Sexual Abuse	.59*	.35	.01 (3,1906)	23.21*
3. HEALTH STATUS Mental Health Sexual Activity Physical Health	.62*	.39	.04 (7,1902)	32.83*

Note: Number of referrals includes all levels of referrals. Blocks of variables were entered into the regression in the order listed in the table. Within blocks the variables are listed in the order in which the stepwise regression selected them. For the total model $R^2 = .39$, $F(7,1902) = 173.45$, $p \leq .0001$.

* $p \leq .0001$ (2-tailed)

Table 3: Frequency and Distribution for Agency-Related Independent Variables (N=291)

Variable	Category	Frequency	Percent
Caseworker Gender	Male	44	15.1 (15.5)*
	Female	239	82.1 (84.5)
	Missing	8	2.7
Caseworker Race	White	60	20.6 (21.2)
	African-American	223	76.6 (78.8)
	Missing	8	2.7
Worker Change	No	219	75.3
	Yes	72	24.7
Number of Places**	1	221	75.9 (78.6)
	2	39	13.4 (13.9)
	3	17	5.8 (6.0)
	4	2	.7 (.7)
	5	1	.3 (.4)
	7	1	.3 (.4)
	9 (Missing)	10	
Type of Placement	Foster Family Home	192	66.0 (67.1)
	Specialized FFH	13	4.5 (4.5)
	Group Home	49	16.8 (17.1)
	Shelter	20	6.9 (7.0)
	Diag/Therapeutic Place	10	3.4 (3.5)
	Own Home	2	.7 (.7)
	Missing	5	1.7
Number of Days Between Assessments (Completion Time)***	17 - 30	5	1.7
	31 - 60	139	47.8
	61 - 90	85	29.2
	91 - 120	31	10.6
	121 - 150	9	3.1
	151 - 180	8	2.8
	181 - 210	3	1.0
	211 - 323	7	.2
	350 - 543	4	.1

* Percentages in parentheses are valid percents.

** Mean = 1.32; s.d. = .73

*** Mean = 80.39; s.d. = 69.69 calculated as days.

Table 4: Referral Completion Rates by Immediacy of Need (N=291)

Method of Calculation	Ratio	Completion Rate
Total number of referrals completed Total number of referrals	317 827	.38
Total urgent/non-routine referrals completed Total urgent/non-routine referrals made	228 512	.45
Number of urgent referrals completed Number of urgent referrals made	81 133	.61
Number of non-routine referrals completed Number of non-routine referrals made	147 379	.39
Number of routine referrals completed NUmber of routine referrals made	89 315	.28

Table 5: Rates of Urgent/Non-routine Referral Completion by Provider (N=291)

Provider	Ratio	Completion Rate
Dental	32 87	.37
Medical	80 142	.56
Reproductive	8 22	.36
Mental Health	51 128	.40
Vision	19 48	.40
Sexual Abuse Evaluation	11 16	.69
Other	27 69	.39

Table 6: Level III Regression Model: Proportion of Need Met (N=229)

Blocks of Variables	R	Adjusted R^2	R^2 Change (df)	F Change
1. DEMOGRAPHICS Age	.24**	.06	.06 (1,227)	14.20*
2. PLACEMENT REASONS	NONE ENTERED			
3. HEALTH STATUS	NONE ENTERED			
4. AGENCY-RELATED Completion Time	.31**	.09	.03 (2,226)	8.57*

Note: Blocks of variables were entered into the regression in the order listed in the table. Within blocks the variables are listed in the order in which the stepwise regression selected them. For the total model R^2 = .09, F(2, 226)= 11.62, p $\leq$ .0001; (2-tailed)
* p $\leq$ .01; ** p $\leq$ .001; (2-tailed)

Infrastructure in Place: Child Care Resource and Referral Agencies as Sources of Child Care Data

Moderated by Yasmina Vinci
The National Association of Child Care Resource and Referral Agencies

Defining the Infrastructure: Child Care Resource and Referral Linking Communities: Building a Better Child Care System - Sarah F. Nordmann, The National Association of Child Care Resource and Referral Agencies

Service Delivery Integration: CCR&R and Re-Shaping Child Care Subsidy Programs - Bruce Liggett, Arizona Child Care Administration

Illinois Child Care Resource and Referral Agencies: Linking Child Care Subsidies and the Universal Child Care Delivery System - Lee Kreader, Ph.D., Illinois Department of Children and Family Services

Standardizing the Child Care Supply and Demand Information Collected by CCR&Rs: The California Experience - Fran Kipnis, California Child Care Resource and Referral Network

Child Care Resource and Referral: Linking Other Systems in Maryland - Sandra Skolnik, Maryland State Child Care Resource Network

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Infrastructure in Place
Child Care Resource & Referral Agencies as Sources of Child Care Data

Introduction to the Panel Presentation

An overwhelming majority of families with young children face stressful, confusing decisions about choosing early care and education settings since affordable quality options are few. Such options are far fewer for families with low or no income. Yet research indicates that the quality of child care has long and short term implications for efforts to achieve and maintain self-sufficiency. In the short term, the ability of the parent to enter and maintain employment or to pursue training, is affected by the dependability of the child care arrangement. Broadly based research confirms the importance of quality care to the development of children. It is also clear from the Perry School Project longitudinal study that quality programs enhance the long-term outcomes for children, thus interrupting the recycling of poverty from generation to generation. A solid infrastructure for quality care and education is necessary to avert the development of a separate track of care for poor families.

One segment of the infrastructure which is community based and which has the capacity to improve the effectiveness of the delivery of child care services by coordinated attention to the supply, demand, and quality, is **child care resource and referral (CCR&R)**. Child Care Resource and Referral agencies counsel parents on the available choices, assist with the development of providers and programs and train individuals who work with children. In fact, some states contract with CCR&R agencies for *enhanced referrals* -- more extensive parent counseling -- for JOBS program participants, in order to ensure consumer education and assistance for the families who may be entering the child care market for the first time.

In documenting their core work, CCR&R agencies collect and maintain data on the supply and demand, and in many cases provide this data to planners and policy-makers at local and state levels. With their dynamic daily contacts with both parents and providers, they represent natural laboratories, still largely untapped, for researchers. For instance, 345 CCR&R agencies responding to a 1992 survey of the National Association of Child Care Resource and Referral Agencies, had in a single year talked to nearly 750,000 parents, had data base information on over 260,000 child care programs and providers, and trained 58,000 individuals who care for children.

Nordmann gives an overview of child care resource and referral, its history and growth, and describes the services typically provided by CCR&R agencies, and the data available from them. It further introduces the papers that follow by discussing some of the uses for CCR&R data by states.

Liggett describes the integration of funding streams for child care in Arizona and universal access of parents to child care resource and referral services; the current efforts look to articulate the new services integration initiative of the Arizona Department of Economic Security with the child care delivery system.

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To give low-income families the greatest possible access to Illinois child care resources, the State of Illinois is committed to a vision of coordinated child care subsidies linked to a universal Child Care Resource and Referral system. As Kreader indicates, in the past five years, Illinois has moved to realize its vision, significantly integrating child care funding streams at the state level and building a system of 16 CCR&R agencies to serve parents -- subsidized and on-subsidized alike -- and child care providers at the community level. As one of its core services, the CCR&R system has begun generating uniform statewide data on child care supply and demand. Within the next few years, supported by a comprehensive new computer system, the CCR&Rs will assume responsibility for the administration of child care vouchers drawn on the coordinated subsidies.

In California CCR&R agencies have been involved in an effort to standardize the collection of data on child care supply and demand. Kipnis discusses the issues encountered in this process, as well as the statistical resources potentially available through CCR&R. Kipnis also treats the role of high quality market rate surveys in building quality child care support for families moving toward self-sufficiency.

Skolnik outlines the development of a child care resource and referral infrastructure in Maryland. Through the funding from both the public and private sectors, and the leadership of a Baltimore-based private, non-profit, Maryland has a highly developed and automated system of CCR&R which is able to produce reliable statistical data which are responsive to local, State, and federal needs.

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Defining the Infrastructure: Child Care Resource and Referral Linking Communities: Building a Better Child Care System

Sarah F. Nordmann, National Association of Child Care Resource and Referral Agencies

What is Child Care Resource and Referral (CCR&R)?

Everyone concerned about child care needs some assistance. Consumers need a single point of access that can help them make sense of all the options and match their needs with available services. Child care providers need reliable training, technical assistance and support to help them remain committed to this highly demanding but under-rewarded profession. Local governments, employers, and community agencies need help in allocating resources effectively to respond to ever-shifting patterns of families' child care needs. Resource and referral services are designed to address the needs of both parents and child care providers: they guide parents to make informed choices in selecting care for their children, and they help to develop and maintain quality child care programs that are responsive to local needs.

Child Care Resource and Referral organizations (CCR&Rs) are increasingly important for their unique ability to provide all of these linkages (see Appendix A). A CCR&R is designed to address the needs of both parents and child care providers: it guides parents to make informed choices in selecting care for their children, and it helps to develop and maintain quality child care programs that are responsive to local needs. Locally-based CCR&Rs offer a decentralized, personal approach to child care information, support, and resource-building. When CCR&Rs are the focal point, the effort to build a child care system is more cohesive, addressing the limits and fragmentation of the current *patchwork* while building on its diversity.

Growth of CCR&R Services

CCR&Rs have been growing steadily across the country since the early 1970s. In 1980, there were approximately 60 CCR&Rs in the United States; today, there are over 500, as well as a National Association of Child Care Resource and Referral Agencies (NACCRRA), founded in 1986. To date, most CCR&Rs are supported by a combination of city, county and/or state funding, federal dependent care funds, businesses, corporate foundations, United Ways, universities, and charitable organizations. In some communities, CCR&Rs are still struggling to develop with only volunteer commitment.

Many CCR&Rs are housed within state or other public agencies. Most, however, are community-based organizations that have been created by parents or child care advocates in response to local needs. Private, nonprofit CCR&Rs have the advantage of being able to attract funds from both the public and private sectors. Even in communities where CCR&R is part of a government body, its mandate is kept separate from regulatory functions, such as child care licensing, so as not to create conflict with the ability to offer impartial training and support to the community (see Appendix B)

More than half the states -- including Alabama, Alaska, California, Florida, Illinois, Maryland, Michigan, Minnesota, New York, Ohio, Oregon, Texas, Virginia, and Washington -- now have statewide CCR&R organizations, often referred to as **networks**; many other states are in the process of developing them. Networks of local or regional CCR&Rs can provide a structure to streamline the allocation of public and private funds, and to develop statewide training, recruitment, supply building, and other child care projects. A network can offer training and technical assistance to local CCR&Rs in order to build and maintain the quality of each agency's services. And perhaps most importantly, a statewide CCR&R network can create a uniform data collection system so that local CCR&Rs all collect comparable information about child care supply and demand, in order to assist state and local planning and resource allocation.

There are over 500 CCR&Rs nationally, assisting families and children of various socioeconomic, cultural, and ethnic backgrounds, creating linkages in the child care delivery system, and providing public education and advocacy through data collection, service delivery and public policy efforts. The specific services provided by CCR&Rs varies depending on the community need, how the service originated, and the funding base.

Services at CCR&Rs

Consumer Education and Referrals to Available Option

One of the primary goals of local CCR&Rs is promoting consumer education and parental choice. CCR&Rs not only provide names and telephone numbers of care givers, but detailed, up-to-date information about the full range of local child care programs and current openings, as well as guidelines for public subsidies and other financial aid.

Referral counselors help parents to become quality-conscious, well-informed consumers through personalized guidance in how to find care that is best suited to their children, and practical tips about what to look for in the programs they visit. A CCR&R does not recommend one program over another; rather, it helps parents clarify what they are looking for and informs them of options they may not have known about. And CCR&Rs often manage voucher systems and other public and private funding mechanisms that help parents meet child care costs.

An especially significant goal of CCR&R is **universal access**: while it is often necessary to target limited child care resources to special populations, CCR&R is one of the few services that can be made available to all families, without regard to income level or other eligibility requirements. In addition, many CCR&Rs strive to reflect the diversity of their communities by providing multilingual and multicultural counseling services.

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Assisting Child Care Providers

CCR&Rs are attuned not only to what parents are looking for, but also to what child care providers need. CCR&Rs enhance child care quality by offering training and technical assistance to providers, and keep programs informed about available subsidies and other resources. This often involves helping develop new resources in the community, as well as teaching providers how to access existing funding.

As CCR&Rs help parents identify options, R&Rs are matching supply and demand. As needs are identified, R&Rs work with the child care provider community, local agencies, and public officials to replenish the supply of child care. CCR&Rs provide start-up assistance to potential providers and implement child care provider recruitment campaigns; in addition, existing providers can work with trained staff on marketing, service enhancement based on demand trends, and retention efforts. In addition, CCR&Rs develop training models, encourage other education initiatives to design courses specifically for child care providers, coordinate and publicize all such community resources. Provider training can greatly enhance the quality of child care.

Since CCR&Rs generally do not have a regulatory, licensing, or supervisory function toward providers, and do not operate child care programs themselves, they are able to offer this assistance in an impartial atmosphere of partnership. Further, by not providing direct child care services themselves, CCR&Rs maintain a neutral position about referring parents to all available service sin the area; they have no vested interest in promoting one form of care over another, and thus foster wider diversity and parental choice in the child care market.

Documenting Trends and Building Supply

Past efforts around the country to document child care supply and demand have often been limited to one-time-only needs assessments or research studies. A resource and referral agency, on the other hand, offers a continual source of child care data, and it can use what it learns from parents and providers to build the supply and improve the quality of child care services. Maintaining a complete and up-to-date list of all child care services in the community and documenting parent needs are integral to a CCR&Rs mission.

A CCR&R is a catalyst and advocate, pinpointing gaps in services so that new responses can be developed effectively. The Child Care Support Center/Save the Children in Atlanta, Georgia, for example, has earned national recognition for its neighborhood-baaed effort to build the supply of family child care and to help providers remain in what is typically a high-turnover field. Many CCR&Rs have collaborated with school systems to develop before- and after-school child care programs; recruited providers willing to care for children whose parents work evening or weekend shifts; and worked with local zoning boards to allow child care programs to develop in neighborhoods where such land uses have been restricted.

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CCR&Rs generate periodic reports about local child care supply and demand, including available services and costs, the ages of children needing care and the neighborhoods where care is most often requested. This wealth of CCR&R information, coupled with demographic data from other sources, can offer critical assistance in child care planning and development for city, county, and state programs.

The National Association of Child Care Resource and Referral Agencies is currently identifying the models and means by which this information can be centrally aggregated and disseminated for national policy and program planning.

Leveraging Resources Through Public/Private Partnerships

In recent years, recognizing that child care problems were affecting turnover, recruitment, and productivity in the workplace, many employers, unions, foundations and charitable organizations have begun taking an active interest in child care issues. They often find that CCR&R agencies are an ideal intermediary to lend their support. A CCR&R's professional expertise in child care, and its connections with local parents and child care providers, make it a highly credible and viable partner. Many CCR&Rs have developed contracts to provide *enhanced* referral services for the employees of both large and small employers. These additional services can include a special phone line, follow-up calls and other personalized support to parents throughout their search for care, and parenting seminars at the workplace.

In order to promote private sector involvement, however, a core of state government support to CCR&R is vital. Public sector leadership in supporting a CCR&R infrastructure allows business to invest in child care, particularly by facilitating the creation of public/private partnerships.

As states develop plans for allocating the new federal child care funds and continue their own efforts to develop services for children and families, child care resource and referral agencies can provide the key to making parental choice a reality. Government and business leaders need a partner that can help them understand child care needs in order to target resources most effectively -- and throughout the country, many are finding that CCR&Rs are the ones to choose.

Data Available from the CCR&R Community

Because CCR&Rs work with both supply and demand issues, they have access to the most pertinent and timely information useful to policy makers regarding the child care delivery system.

Supply data available through CCR&Rs typically are more detailed and comprehensive than child care regulatory offices. This is due to the nature of CCR&R service delivery. Because

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R&Rs are involved in recruitment, supply replenishment, and helping parents identify options, R&Rs gather information at the city and county levels; some have coded data by census geography. Many states have compiled data for statewide analysis.

Data are typically gathered for licensed or regulated child care providers. Depending how providers are regulated, data can be available on legally exempt providers. Data sets available regarding child care providers include name, address, city, state, zip, hours of service, fees, for service, special services provided, organizational affiliation (religious, corporate, or other), characteristics of the facility (i.e., no smoking), and licensed capacity.

While most R&Rs create computerized databases of licensed center and family homes, some R&Rs gather information regarding license exempt providers in their communities. Another pool of providers includes unlicensed, illegal care. This is the most difficult to measure since no one regulates or monitors these types of providers. Estimates of the number of unlicensed providers vary greatly; currently, there is no statistical model to measure the supply of unregulated providers. Analysts perform sample surveys of parents child care choices as one way of estimating use of unregulated child care, however.

Demand data available through R&R can provide a wealth of up-to-date information for policy makers and program planners alike. Using questionnaires or *Intake* forms, counselors gather information on a daily basis. Data gathered includes type of care preferred, area care desired, amount able to pay for care, hours care needed, days of week care needed, ages of children who need care, and special services required. The type of data gathered depends on the ancillary or other primary services provided by the R&R. Some gather data on employment status, size of family, public support received by families, and more. Data can then be used in assessing the need for child care in communities.

How States Use Data

The CCR&R has evolved to be a useful resource for states in implementing programs and shaping policy. CCR&Rs are noted for gathering copious amounts of data, referring to all aspects of the child care delivery system. State planners have used this information in developing statewide CCR&R networks, where the state funds portions of services typically with some private matching of funds.

In addition, as federal funds have been identified to enhance children's services, CCR&Rs have been sources of information in planning the effective use and distribution of funds throughout states to include reducing the size of voucher waiting lists, modifying the reimbursement rates of voucher/certificates, analyzing staffing patterns at licensing and other regulatory agencies, enhancing resource and referral services for the communities in most need of services, increasing training opportunities for early childhood educators, creating resource clearinghouses for early childhood educators, and the creation of supply in targeted areas.

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CCR&Rs are continually involved in assessing market rates of child care for a variety of purposes; in addition, they have been instrumental in assessing the nature and uses of transitional child care services. States look to CCR&Rs to monitor unmet child care needs on a regular basis. CCR&Rs also work with State officials in projecting demand for child care based on demographics and CCR&R data.

Qualitative and quantitative data are useful in a variety of policy areas including creation, interpretation, and modification of regulations, policy analysis vis a vis other regulatory agencies, federal fund distribution, and service delivery of related child care systems (child care subsidies, public school attendance, and wrap around child care with programs such as Head Start).

The papers which follow are examples of efforts to collaborate to shape the child care delivery system toward self-sufficiency -- Arizona, California, Illinois, and Maryland.

References

Building a Better Child Care System: The Role of Child Care Resource & Referral Agencies, 1992. Dan Bellm, in partnership with the National Association of Child Care Resource & Referral Agencies.

Appendix A CCR&Rs Linking the Child Care Delivery System

POLICY/ADVOCACY

- Communities
- Local & State Government
- Employers
- Federal Government

* education on community needs
* data collection and research
* education on work/family issues
* support on policy development for children, youth, and families

FAMILIES

* education on child development & quality care

* linked with child care providers
* linked with financial and training resources

CCR&Rs

CHILD CARE PROVIDERS

* education on professional & program development

* linked with financial resources
* resources for professional and program development

RESOURCES (public & private)

* vouchers and tuition assistance programs
* USDA Food Programs
* Headstart

Appendix B

CCR&RS IN THE UNITED STATES
Organizational Affiliation

Primary Affiliation	% CCR&Rs
Stand Alone Agency	42%
Government	8%
University & Colleges	4%
Community College	2%
CAP Agency	11%
Family Service Agency	8%
YW/MCA	1%
Child Care Provider/Association	16%
Other	8%

Source: "Survey of CCR&Rs, 1991", National Association of Child Care Resource & Referral Agencies, May 1992

Primary Sources of Funding
(percent of CCR&Rs receiving funding)

		Amount Funded	
Source	0%	<50%	>50%
Government	11%	19%	70%
Employer Fees for Service	48%	42%	10%
United Way	68%	33%	1%
Contributions	59%	39%	2%
User Fees	64%	35%	1%
Other	70%	29%	6%

"Government" includes local, state, and federal agencies; "employer fees" are typically a contracted service to help their employees only; "United Way" funds are available to CCR&Rs; "contributions" includes donations from foundations, employers, and other philanthropic groups; "user fees" are fees charged to families, employers, and child care providers for a wide range of support and information; "other" includes funds from [illegible] project within the community, membership fees, fees for services to the community, and other in-kind donations from individuals and communities.

Source: "Survey of CCR&Rs, 1991", National Association of Child Care Resource & Referral Agencies, May 1992

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Service Delivery Integration: CCR&R and Re-Shaping Child Care Subsidy Programs

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Purpose

The purpose of this presentation is to review the integration of child care programs administered by the Department, describe the implementation of Resources and Referral services, and to share a new model for further integration of welfare and child care services.

Background

The DES has provided child care subsidy payments to low income families since the mid-1970s. While the number of families receiving assistance grew steadily since the beginning of subsidy payments, a number of demographic. social, economic, public policy changes converged during the late 1980s that significantly transformed child care programs and service delivery. The state of Arizona's population continued to grow at rates beyond the national average. The increase in single parent families and families in which both parents are employed greatly increased the demand for child care. Many of the new jobs that were created were part time or low wage. As a result, the number of families served and funds expended for child care subsidy payments increased by 40 percent from 1986 to 1990. After years of national debate, consensus emerged for an expanded federal role in funding child care programs to address welfare dependence, families at risk of welfare dependency, and broad child care issues of affordability, availability, and cost.

In July 1991, the DES established a Child Care Administration with the Division of Children and Family Services. The purpose for establishing this administration was to develop a focal point for coordinating an integrating child care programs and services for low income families and to provide leadership to address broad public issues affecting child care in Arizona.

The Child Care Administration is responsible for all Department child care policy, payments, and provider relations and administers field operations staff that determine eligibility, authorize benefits, and certify family day care homes throughout the state. The establishment of this administration helps ensure that programs are integrated, coordinated, and accountable. An integrated system will, to the extent allowable by statute, federal regulations, and available funding, provide comparable benefits to families regardless of categorical eligibility or source of funding. A coherent and efficient system that ensures continuity of care can be developed when requirements for eligibility, provider standards, and payment rates are coordinated and consistent across various programs.

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The DES has been designated the lead state agency by the Governor, under the Child Care and Development Block Grant (CCDBG). This role requires extensive planning, coordination, and interagency collaboration. To meet the broad mandates of the CCDBG, the Department has established interagency policy and working committees and an advisory committee. The following mission and goals of the Child Care Administration establish the direction for future activities.

Mission

To provide families with child care assistance that increases or maintains self-sufficiency and to promote the development of child care to meet the needs of Arizona's families.

Goals

1. To develop a comprehensive, integrated, and coordinated child care service delivery system.

2. To provide child care benefits on behalf of low income families that support informed parental choice of providers.

3. To deliver services through an efficient, effective, accountable, and responsive statewide system.

4. To improve the quality, availability, and affordability of child care for all families.

Overview of DES Child Care Programs and Services

The Child Care Administration manages four major child care programs and five fund sources that provide assistance to low income families.

The State Subsidy program provides fixed hourly rates of reimbursement based on income and family size. These rates do not take into account child age, type of care, or regional differences in the cost of care. Provider charges to families are not tracked and low income families often must make co-payments that exceed their ability to pay. For example, a family of three, in the Phoenix and Tucson metropolitan areas, with two preschool children, that earns minimum wage and uses center-based care is expected to make co-payments that range from 25 to 35 percent of their gross monthly income (based on *median* center charges). Families unable to make such co-payments are too often forced to use substandard care, unlawful care, or no caregiver at all (i.e., latchkey).

Under the Family Support Act of 1988, the DES developed Transitional Child Care, JOBS, and AFDC-Employed child care programs that pay providers based on local market rates and establish eligible families' share of costs based on their ability to pay. A family, identical to the one described above, that is eligible for and receiving Transitional Child Care benefits after entering AFDC, would make co-payments that are less than 5 percent of their gross monthly income.

The Family Support Act child care programs implemented in 1990 by the Department were designed to greatly increase the likelihood of self-sufficiency for eligible families and serve as a model for future program development. Yet, due to limited funding, it was not possible to make similar benefit levels available to non-AFDC related families. The At-Risk Child Care program, enacted in November 1990, provided critically needed federal funds to address families that are not at risk of AFDC eligibility. By providing these market rate based child care benefits to the working poor, families are better able to maintain self-sufficiency.

The Child Care and Development Block Grant Act of 1990 (CCBDG) provided federal funds to the state to improve the affordability, availability, and quality of child care. The DES was designated the lead agency by the Governor to administer the CCDBG. The CCDBG requires that the preponderance of funds be used for subsidy to eligible families and that the lowest income families and special needs children receive priority. Twenty-five percent of the funds are *set aside* and must be used for early childhood development and before- and after-school services and specified quality improvement activities. In January 1992, the Department began using CCDBG funds to subsidize child care for families that need child care for employment, education, job training, and job search.

The coordination of the provider requirements, payment methods, and eligibility criteria for the state Child Day Care Subsidy, Family Support Act, At-Risk, and CCDBG programs enables the maximum integration possible. By maximizing federal funds, the Department is providing enhanced benefits to low income families. Yet, due to federal funding limits, there remains a state subsidy program that pays based on fixed rates versus market-based rates.

Beginning of a Child Care Resource and Referral System

In 1989, the American Express Foundation provided funding to a local advocacy organization to develop a plan for statewide resource and referral services. The DES was an active participant in the planning process. As a result of these efforts, legislation was passed in 1990 authorizing DES to establish a statewide system of resource and referral services through community-based agencies. In 1991, DES began to phase in resource and referral services in one urban and one rural county using federal Dependent Care Grant funds. During 1992, the Department used CCDBG funds to expand resource and referral to four additional counties, including the Phoenix metropolitan area. Currently, resource and referral services are available to approximately 80 percent of the state's population. By October 1993, the entire state will have resource and referral available in all 15 counties. It is estimated that almost $1 million will be required to maintain the statewide system annually.

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Preliminary data from Arizona's resource and referral system reflects many of the national trends. Highlights of this data are listed below:

- 50 percent of requests are for children ages birth through one year; 29 percent of requests are for preschool children; and 21 percent are for older children.

- 26 percent of parents using these services reported incomes below the federal poverty level.

- 57 percent of requests for referral were for family child care; 36 percent of requests were for center-based care; and 7 percent of the requests were for other types of care.

As the statewide system of resource and referral continues to develop, many opportunities exist for further integration with the state's program of child care subsidy benefits. Expanded use of resource and referral for public assistance clients and JOBS participants is being explored. There may be opportunities for increased cost sharing of these services under the IV-A funded child care programs.

During the past several months, the Department has been developing a new model for integrated service delivery. Once the model is implemented, there may be opportunities to improve the quality of services to families by linking resource and referral to the model. The proposed model for integrated services is described in the following summary.

INTEGRATED CLIENT SERVICE DELIVERY MODEL (POD)

WORK GROUP

On November 13, 1992, as a part of the Arizona Department of Economic Security (ADES), Total Quality Management (TQM) Model District effort initiated by DES Director, Charles Cowan, a work group was formed to design a model office which integrated the delivery of services to clients at the local office level. Services were included in the effort based on the greatest amount of overlap of benefits received. The services included were:

1) Child Support Enforcement, as administered by the ADES Division of Child Support Enforcement (DCSE).

2) Financial assistance programs including AFDC and AFDC-UP (known in Arizona as the Two Parent Employment Program or TPEP), Food Stamps, as administered by the DES Division of Benefits and Medical Eligibility (DBME), and the various Medical Assistance programs for which DBME is responsible for the eligibility determination.

3) Job Opportunities and Basic Skills (JOBS) program, as administered by the DES Division of Employment and Rehabilitation Services (DERS).

4) Food Stamp Employment and Training program administered by the DERS.

5) Child care assistance programs, as administered by the DES Division of Children and Family Services (DCFS).

The Integrated Services workgroup is one of three teams working in a coordinated effort under the sponsorship of the Assistant Director of the DES Division of Benefits and Medical Eligibility. The other two teams are responsible for quality enhancements to DBME eligibility determinations and for intake process flow enhancements within DBME programs. These three teams make up the Model District effort.

The Integrated Services effort incorporates the use of a Steering Committee made up of the Assistant Directors and the Program Administrators responsible for the included programs, as well as the Assistant Director and a Systems Manager for the Division of Data Administration (DDA). This group, chaired by the workgroup sponsor, meets every other week to review workgroup progress and to provide direction for the effort.

The workgroup originally consisted of six members representing specific program areas and the team leader, who is the Project Control Manager of the Family Investment Initiative (FII). The team was reduced to six total members after a lengthy illness forced one member to leave the team in December, 1992. The workgroup utilizes the expertise of a representative of the ADES Office of Human Resources as a facilitator.

INTEGRATION MODEL

The Integrated Client Service Delivery Model is the end product of this workgroup. The workgroup set two specific goals for the model:

1) Increase the effectiveness of the service delivery system by reducing the time it takes for eligible clients to receive services needed to move to self-sufficiency. This would be accomplished by:

   a. Reducing the number of visits a client must make to various program offices,

   b. Integrating the application process for all programs into one single application and interview.

2) Establish a delivery system which emphasizes self-sufficiency rather than dependency by:

   a. Making services available in an order that moves a client to self-sufficiency,

   b. Establishing a working environment in which program areas within DES are encouraged to communicate and share client information in order to enhance the delivery of services by all program areas.

The workgroup was given the following parameters in which to work:

1) Develop a model which will work within the current operating automation environment,

2) The model must be capable of being applied throughout the state, with only minor modifications,

3) The model must be able to be implemented within existing ADES facilities.

The Integrated Services Model is highlighted by a number of changes to the service delivery patterns currently in place for the various programs. First, clients are required to complete a single application consisting of the minimum number of questions needed to complete a brief assessment of needs for the family to become self-sufficient.

Other program specific information is gathered on supplements to the application, as needed. Second, specific eligibility data is gathered and entered into an existing automated system during an initial orientation and assessment. This assessment is designed to emphasize self-sufficiency through employment or other means, determine the needs of the family to become self-sufficient, determine eligibility for various supportive programs such as financial assistance and child care and determine the appropriate track within the integrated service delivery model for the client to follow in order to move toward self-sufficiency.

Providing all information needed to complete the initial assessment is available at the time of application, a client will understand upon completion of the assessment what services are available and what to expect in the way of departmental commitment to moving the individual and family to self-sufficiency.

Finally, the client has one primary case worker; no matter what services are to be received. This primary case worker has the responsibility for ensuring that all supportive service staff are aware of any situational changes which the client may report and for the ongoing evaluation of the plan for self-sufficiency of the client and family.

INTAKE

The individual, through the use of bilingual signs in the local office, is directed to an area that will have applications available. These applications are no more than two pages in length and gather only the information needed to determine that the client is in the proper geographic area, what the client's needs are and what services the client may potentially be eligible for. The signs direct the client to complete the application and then proceed to the Client Service Worker (CSW); a clerical worker located at the front desk within the lobby.

The responsibility of the CSW is to review the application for completeness and ensure that the individual is in the appropriate office, based upon the client's residential zip code. The CSW will also identify any special needs the client may have such as an interpreter. The worker will ensure the client moves on to the next step in the process in a timely manner.

The client will be directed by the CSW to either an orientation or an interview with a Program Service Specialist. The orientation is a fifteen to thirty minute group session which outlines the POD concept. It also provides information on employment and other self-sufficiency services available to all persons regardless of income or other eligibility factors. Highlighted will be information on job referrals, job placement and non-public assistance child support enforcement.

Part of this orientation is done by video tape while the remainder is done by DES Job Service staff co-located in the office. The entire orientation will be available in both English and Spanish. These workshops will be conducted periodically throughout the day. Clients who cannot be seen immediately by a Program Service Specialist (PSS) will be directed first to the orientation. All clients will be encouraged to participate in the orientation and those with a work program participation requirement will be required to attend.

The interview with the PSS is a one to two hour meeting designed to determine what is needed to move the client and family toward self-sufficiency. The PSS will review the application to identify potential need and eligibility. For those who are unable to complete the application, due to various handicaps, the PSS will complete it at this time. Because employment is a primary focus of the model, the PSS will discuss employment expectations with the client.

A brief assessment of services needed to meet the employment goals is then completed with the client. The PSS will then gather any program specific information necessary to determine eligibility for individual support programs. Eligibility is completed for any programs necessary or requested by the client.

If eligibility for either AFDC or Food Stamps is to be completed, relevant family information is keyed into the Arizona Technical Eligibility Computer System (AZTECS), the FAMIS certified eligibility system used in Arizona. All applications for medical assistance will be entered into the APIS/FOLD system. The eligibility process is completed during the interview for clients who have provided all the necessary information.

For those who are in need of child care only, the required information is gathered and relevant information is keyed into the Arizona Social Services Information and Statistical Tracking System (ASSISTS). Those persons requiring child care assistance and who have identified a provider who is registered to receive DES payment will be approved for the needed services and authorization will be input into ASSISTS. Those determined eligible, but who have not selected an existing DES registered provider, will be advised of their eligibility and referred to their Primary Case Worker (see below) for assistance in securing an appropriate provider. Data will not be entered into ASSISTS until a provider is secured.

Those for whom employment is indicated will be assessed to determine the appropriate JOBS track and to determine the job readiness for those who receive Food Stamps but do not receive AFDC. The PSS will ensure all necessary referrals are completed either in the automated systems or by way of existing referral processes.

Those having need of child support services will provide the necessary absent parent and child support information on manual forms to be routed to the child support workers, regardless of eligibility for AFDC. At this time, the client will be given the opportunity to open an NPA case. The forms to be used will be the current DCSE Absent Parent questionnaires. In addition, the PSS will be responsible for securing the necessary Paternity Affidavits and the necessary signatures on Requests for Establishments of Paternity.

During the interview, the client will be given an explanation of their rights and responsibilities and will receive a pamphlet. Also, a determination of the primary program area of continued service will be made. The Program Service Specialist will make a point to introduce the client to the ongoing primary case worker within the primary program area at the conclusion of the interview (Primary program is the program area which will likely produce the most contact with the client during maintenance of the case). The following guidelines are to be used to determine the primary program area:

1) Those who are to participate in JOBS, Food Stamp Employment and Training or other available employment services will have an employment based Primary Case Worker,

2) Those for whom employment services are not appropriate at the time of application for financial assistance will have a financial services based Primary Case Worker,

3) Those who are not participating in any employment services nor receive AFDC, Food Stamps or Medical Assistance but who do receive child care services will have a Primary Case Worker assigned from the Child Care area,

4) Those persons who receive only child support services will be assigned to a Primary Case Worker from the Child Support area.

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Clients who have not attended the orientation will be asked to do so at the conclusion of the interview.

MAINTENANCE

Maintenance is a team activity which includes all program area specialists who may have services available to assist the family to become self-sufficient. All client contact is done through the Primary Case Worker and all notices sent to the client are sent out under the name of that worker.

All situational changes are reported to the Primary Case Worker, who is responsible for disseminating the change information to each of the other program areas currently involved with the client. For example, a client who is participating in JOBS, AFDC and has a child care case will have an employment based Primary Case Worker. Should this client find employment, the change must be reported to the Primary Case Worker, who completes a change form; copies will be routed to all other program areas for determination of the impact of the change.

The Primary Case Worker is responsible for keeping all information reported by the client. All other program areas must keep only the reports which are pertinent to their individual program area. This will enable each program area to have a complete file of the information necessary for audit of their program.

In addition, there is a single file in which all data regarding the client can be found. The exception to this is child support. The legal assistant within the POD will determine if the information is pertinent to the child support case and forward all necessary information to the appropriate unit at the Encanto site (the child support file will be maintained at the DCSE Encanto facility).

Program changes for the primary program area are done by the Primary Case Worker. Maintenance for program areas other than the Primary Program area is done by a pool of staff from that program area.

Currently, both the Division of Children and Family Services and the Division of Benefits and Medical Eligibility complete eligibility determinations for services based upon very similar information. At present, it is reported that child care specialists spend the majority of their time completing these eligibility determinations rather than providing support in establishing secure child care arrangements. As a result, eligibility for child care programs is being shifted to those who determine other financial eligibility.

The Child Support function is being divided between the integrated office and the DCSE centralized staff; whom are currently located at the Encanto site. The assessment worker will gather the information and fill out the absent parent questionnaire. If paternity is an issue, the assessment worker will be responsible for preparing the paternity affidavit and having the custodial parent sign the Request for Paternity. This will eliminate the need for the custodial parent to attend a paternity workshop at the Encanto office.

Pod staff will be responsible for up-front locates including telephone checks, motor vehicle registration checks, Base Wage and Unemployment checks for all cases referred for action. If post office checks and/or written requests for employment verification are needed, the case file will be sent to the Encanto facility.

Maintenance will also involve responding to child support client inquiries for those cases served through the model. Any government inquiries will be directed to the appropriate unit at the DCSE office. The model office will also be responsible for building the physical case files and updating ATLAS as the client moves from public assistance to self-sufficiency. Obtaining court orders when not provided by the custodial parent and debt set-up will be handled by the appropriate Encanto staff.

Employment services will include case management services for as many clients as resources will allow. The priority for service is for AFDC/JOBS clients. Currently, employment case managers emphasize coordination of services by utilizing existing resources to the most advantage of the client. This will continue under the Pod model. As resources are made available, other non-JOBS clients will be given the opportunity for case management services. JOBS Primary Case Managers are responsible for the case beginning with selection of the client from the referral file and continuing until the client is closed.

SCHEDULED REVIEWS

All six month eligibility reviews and Food Stamp recertifications will be done by the assessment unit comprised of financial eligibility staff. By centralizing all reviews and recertifications, it is hoped that the client will be required to appear at the local office for fewer appointments; reducing both client and staff time in processing the case.

OFFICE LAYOUT

The physical setup of the office is designed so that the integration of services is stressed. Individual pod areas will have no partitions or other barriers to effective communication. Pods of staff will be located together. Each pod will consist of staff representing each of the program areas. One staff person may be a member of several pods in those locations where specific program service requests within the coverage area do not warrant enough staff to be represented in each pod. All client services will be administered by staff within the pod. To ensure proper security and confidentiality, clients will not be admitted to the pod area. Interview rooms will be established in other areas of the office to be used for all confidential interviews.

Finally, parents can leave their children in an on-site day room while they are participating in the initial orientation and the interview. It is anticipated that much of the direct staffing of the day room can be accomplished by utilizing (Community Work Experience Program (CWEP) workers through the JOBS program.

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Illinois Child Care Resource and Referral Agencies: Linking Child Care Subsidies and the Universal Child Care Delivery System

J. Lee Kreader, Ph.D., Illinois Department of Children and Family Services

Introduction: The Illinois Child Care Vision

The State of Illinois, over the past five years, has committed significant effort and funds to realizing a vision for subsidized child care -- single local points of entry to the child care subsidy system for parents and child care providers, offering access to *seamless* child care funding. Recognizing the importance of child care to the success of families moving out of poverty, Illinois looks to Child Care Resource and Referral agencies (CCR&Rs) as not only the local administrators of child care subsidies, but also the local sources of consumer education and information on child care options. Through CCR&Rs, parents can learn the indicators of quality child care and select quality child care arrangements which meet their children's needs.

At the state level, the child care vision calls for coordinated administration of child care subsidies for all the various overlapping pools of eligible families and for all the child care providers who serve them. The state will develop policies to facilitate uninterrupted child care as families move from one funding stream to another.

At the community level, the Illinois vision rests on a statewide system of Child Care Resource and Referral agencies and will use this community-based network to administer all the coordinated subsidies. CCR&Rs will obtain necessary eligibility information from all participating families and process payments to all providers participating in the state's voucher payment system.

The publicly-subsidized child care system will be an integral part of Illinois' universal child care delivery system. The CCR&R system makes its core services available to all parents (including those not participating in subsidy programs) and all providers in the state. Core services include:

- child care referrals and consumer education on quality child care to all families,
- training and technical support for all legal child caregivers in Illinois,
- assistance in entering the child care profession, and
- generation and management of data on the state's overall child care supply and demand.

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Background and Guiding Principles

Illinois' two-part vision was first articulated in the Spring of 1989 by the Governor's Child Care Summit, convened to help Illinois plan its implementation of the Family Support Act. Summit participants included representatives of the state departments which fund early care and education and Illinois child care leaders from the private sector.

Guiding the vision are five key principles identified by the members of the Child Care Summit:

1. The publicly-subsidized child care system - like the overall system - should provide parents with a range of options, including center-based care and family child care, and should have a mechanism for educating parents so that they can make informed decisions about their children's care.

2. All families seeking child care must have easy access both to information and to the child care services they need.

3. The publicly-subsidized system, like the overall system, should promote maximum continuity of care, so that both children and their parents benefit from stable and long-term relationships with caregivers, and parents are able to pursue employment, education, or training opportunities.

4. All child care should meet children's need for a secure and nurturing environment which promotes all aspects of healthy development and prepares children for success in school.

5. All child care should enhance the capacity of families to provide for their children's physical, emotional, and educational needs.

Since 1989, Illinois has been moving to realize its vision. So far, the work has proceeded on two largely parallel tracks. At the community level, Illinois has developed its universal system of child care resource and referral. At the state level, there has been increased coordination of the administration of public child care subsidies. In the next two to three years, these parallel tracks will converge, as the CCR&Rs assume responsibility for voucher/certificate payments. Some CCR&Rs have already become involved in several aspects of the child care voucher process. Illinois has also begun designing a comprehensive computer system which one day will link the community-based CCR&Rs with the state departments which administer child care subsidies.

This paper will describe in detail the work in *laying the tracks* and the data which has been and will be accessible through the Illinois child care delivery system.

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The Illinois Context

Two state departments with major responsibility for child care subsidies are the initial focus for the system:

1. Department of Public Aid (DPA) - is the lead agency for the Family Support Act; it also administers a state (not county-based) system of public assistance.
2. Department of Children and Family Services (DCFS) - is the lead agency for the Child Care and Development Block Grant; in addition, by statute, it is responsible for the coordination of child care services for the state through its Office of Child Development.

Other divisions of government also play key roles in the child care delivery system including the state Board of Education which funds Pre-Kindergarten programs and the federal government which funds the Head Start.

Illinois has a long-standing commitment, explicitly reinforced by the Child Care Summit, to two methods of making subsidy payments. First, vouchers are available to pay for the care of individual children. Administered by the Department of Children and Family Services through its regional offices, this *client-based care* process will ultimately be transferred to the CCR&Rs. Second, contracts are established with child care providers to purchase blocks of spaces for eligible children. This process, currently administered by the Department of Children and Family Services' regional offices as *site-administered care*, will be retained by DCFS.

Track One: Creation of the Universal Illinois Child Care Resource and Referral System.

The Department of Children and Family Services, with funding from American Express, began development of CCR&R standards in 1988. By 1989, standards of operation were in place which emphasized the importance of CCR&Rs' strong identities in the communities they serve; legitimacy and freedom from bias with parents and providers alike; and capacity to deliver core services, including analysis of data on the local child care supply and demand.

From mid-1989 to mid-1991, the United Way of Chicago played key role in the creation of the Illinois child care delivery system. The United Way received a grant from the Department of Public Aid to select, train, and provide initial funding to the 16 CCR&R agencies which would make up the Illinois CCR&R System. Guiding the selection process were two basic considerations – each potential CCR&R needed not only to meet the Illinois CCR&R standards outlined above, but also to be willing eventually to administer coordinated subsidies and participate in the planning of the new public subsidy system. By July 1991, the 16 CCR&Rs had been selected or created. At that time, DCFS assumed ongoing responsibility for funding and administration of the CCR&R system.

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Data Generated by the CCR&R System. Like other states, including California, Illinois has gone through a rigorous process of defining child care data elements. Because child care in Illinois -- in America -- is so wonderfully diverse, parents have options, challenging those who *presume* to collect data on it! Illinois first collected statewide child care data in fiscal year 1992. Data is compiled on child care providers and on parents and children requesting child care services through the system. It has been published in the Department of Children and Family Services *1992 Report on Child Day Care*.

Provider data is aggregated at both the state and local CCR&R service delivery areas levels. Computerized data is organized by each type of legal care: licensed and license-exempt centers and family child care homes and licensed group child care homes. It includes the numbers of each type, capacity of each type, numbers of each type offering a variety of schedules, and other information. Appendix A, taken from the *1992 Report on Child Day Care* shows the growth of CCR&R provider records between June 30, 1991 and June 30, 1992. Appendix B shows the variety of provider schedules listed with the CCR&Rs. Information can be cross tabulated to evaluate the availability of care by type of provider.

Parent/child data is also aggregated at both the state and local CCR&R levels. Data captured by the CCR&R system includes the number of families contacting the CCR&RS, numbers of families potentially eligible for Child Care and Development Block Grant subsidy (62% in fiscal year 1992), numbers receiving Aid to Families with Dependent Children sometime within the past 12 months (22% in fiscal year 1992), ages of children needing child care (approximately 48% infants and toddlers), and child care preferences by types of care and schedules requested (see Appendix C and D).

In addition, the CCR&Rs capture data on children with special needs requiring child care. Some of this data has recently been used in *Toward New Strategies for Inclusion: How Child Care Resource and Referral Agencies Can Support the Inclusion of Children with Special Needs and Disabilities in Regular Child Care Settings*, a report sponsored by DCFS and DPA

The complete data is an exceptional starting point for future longitudinal research on child care supply and demand. The Department of Children and Family Services has had preliminary conversations with faculty at the University of Illinois School of Human Resources and Family Studies about using the CCR&R data in several research projects.

Track Two: Coordination of DPA and DCFS Subsidy Systems

The second track of the Illinois system is equally complex, requiring the integration of various programs managed by different departments from divergent funding streams. Through interagency agreements, the Department of Children and Family Services operates two Department of Public Aid child care programs -- Transitional Child Care (TCC) and the Title IV-A *At Risk* Child Care. The Department of Children and Family Services continues to operate the

Employment/Training Subsidized Child Care funded by the Child Care and Development Block Grant (CCDBG) and other funds including state General Revenue Funds.

One key success of the integration includes establishing the same rates throughout all funding streams of both the Department of Public Aid and the Department of Children and Family Services. This was done based on the Department of Public Aid's market rate survey for which the CCR&R system was one source for this information.

A second success has been the adoption by both departments of uniform participation standards for providers. With this foundation, the state was able to create a universal family application and eligibility and provider certification form in 1992. Billing has also been consolidated and standardized so that there will be a universal billing form to be used in late 1993.

An important study published by the Department of Public Aid in September 1991, *Child Care and AFDC Recipients in Illinois: Patterns, Problems and Needs,* has reinforced the state's commitment to its child care vision. A survey of over 7,000 AFDC clients -- augmented by focus groups, interviews, and a survey of 1,001 child care providers -- the study asked who is taking care of the children, what factors influenced the types of providers used, to what extent do these families use the state child care subsidy programs, and how is child care implicated in the willingness or ability of these parents to enter work or training.

The study found a significant difference between the type of care used by parents and the type they preferred. Only 19% of those using child care had their children enrolled in a child care center or nursery school, even though more than 50% expressed a preference for these more formal types of care. Also, significantly, 42% of all respondents said child care problems prevented them from working full time, 39% said child care problems prevented them from going to school, and 20% of those what had returned to AFDC during the past year said they left work due to child care difficulties.

The Two Tracks Converge: Illinois CCR&Rs' Growing Role in Subsidy Programs

Illinois' two child care tracks are scheduled to converge within the next two to three years. Already, the tracks have met in several ways.

1. **Educating Subsidy-Eligible Families on Quality Child Care.** CCR&Rs make consumer education and child care referrals available to all Department of Public Aid families. An entertaining *All My Child Care* video, which makes clients aware of available subsidies and urges them to contact their local CCR&R, plays in Department of Public Aid offices. Printed materials reinforce these messages and also point out that CCR&Rs can help people interested in entering the child care profession.

2. **Enhanced Referrals for Subsidy-Eligible Families.** During fiscal year 1992, five CCR&Rs piloted *enhanced* referrals to some families receiving DPA-funded child care. The enhanced

referral process provides referrals to providers with confirmed vacancies -- thus reducing parents' search time -- and gives families more in-depth child care counseling and consumer education. The process decreases the number of families giving up on the child care search and enables parents to focus their search more fully on quality issues. The process also identifies barriers to making lasting child care arrangements and provides data on the availability of care to eligible families.

3. **Piloting CCR&R administration of TCC and Title IV-A Subsidies**. August 1993 marks the beginning of the Cook County CCR&R's administration of TCC and IV-A vouchers. The process and outcomes at this first CCR&R site will be measured to ensure high quality and replicability.

4. **Future CCR&R Administration of Direct Payments in Lieu of Income Disregard Child Care**. The Illinois General Assembly voted in 1993 to move to a direct payment method in place of the Earned Income Child Care Disregard method of subtracting a family's child care expenses from their monthly income when calculating welfare benefits. The Department of Public Aid has begun planning with the CCR&R system for CCR&R administration of this new program.

5. **Future Automated Links between CCR&Rs and State Departments**. Ultimately, the CCR&Rs and the Departments of Public Aid and Children and Family Services will be linked by a comprehensive computer system which will support the processing of eligibility determinations and payments, management of the multiple funding streams, and accounting and reporting to the federal government, as well as support the CCR&Rs' core services. A study completed in March 1990 established the feasibility of this future system; a design study was completed in June 1992.

Conclusion

As Illinois' CCR&R and coordinated subsidy tracks come together, the data generated by the CCR&Rs in their work will be invaluable, not only for measuring accomplishments, but also for planning ongoing improvements to the child care subsidy system. The goal remains the same as outlined five years ago by the Governor's Child Care Summit, to give low-income families the greatest possible access to all the state's child care resources.

Appendix A Child Care Services in Illinois: Sample Statewide and SDA Data on Child Care Supply

TABLE VI

CHILD CARE PROVIDERS REGISTERED WITH CCR&Rs

	6/30/91		6/30/92			
	Providers	Spaces	Providers		Spaces	
Licensed						
Family Day Care	4,725	31,299	5,590	(18%)*	37,190	(19%)*
Group Day Care	35	373	87	(149%)	977	(162%)
Centers	2,179	134,347	2,377	(9%)	139,324	(4%)
Total Licensed	6,939	166,019	8,076	(16%)	177,513	(7%)
License-exempt						
Family Day Care	421	999	477	(13%)*	1,348	(35%)*
Centers	610	35,239	709	(16%)	38,565	(9%)
Total Lic. Exempt	1,031	36,238	1,186	(13%)	39,913	(10%)
TOTAL LICENSED & LIC. EXEMPT FACILITIES	7,999	202,286	9,262	(16%)	217,404	(7%)

* percent growth in spaces and providers from July 1, 1991 to June 30, 1992

Source: 1992 Report on Child Day Care, Illinois Department of Children & Family Services, 1993.

Appendix B Child Care Services in Illinois: Types of Child Care Arrangements and Schedules of Providers

TABLE VIII

PROVIDER SCHEDULE ARRANGEMENTS

Schedule	# of Providers*
Full time	7,266
Temporary/emergency	2,090
Drop-in	1,699
Twenty-four hour	159
Evening hours	923
Overnight	492
Weekend	188
Vacation/holidays	227
Flexible hours	2,263

* Although these figures are based on 9,262 providers registered with the CCR&Rs, it is possible that not all providers have informed the CCR&R of their schedules.

Source: 1992 Report on Child Day Care, Illinois Department of Children & Family Services, 1993.

Appendix C Children and Family Child Care Needs in Illinois: Parent/Child Data Available

TABLE III

TYPES OF CARE REQUESTS TO CCR&Rs

Type of Care	Number of Families Requesting	
Center	3,245	(13.0%)
Day Care Home	9,771	(39.0%)
In-Home	906	(4.0%)
Center or Day Care Home	9,227	(39.0%)
Center or In-Home	65	(0.3%)
Day Care Home or In-Home	853	(3.0%)
Center or Day Care Home or In-Home	798	(3.0%)
	24,865	(101.3%)

Source: 1992 Report on Child Day Care, Illinois Department of Children & Family Services, 1993.

Appendix D Family Schedule Requests

TABLE IV

FAMILY SCHEDULE REQUESTS

Schedule	Number of Children*
Full year	24,443
Temporary/emergency	739
Drop-in	128
Twenty-four hour	20
Evening hours	1,403
Overnight	367
Weekend	344
Vacation/holidays	344
Flexible hours	3,782

*one child may request multiple categories

Source: 1992 Report on Child Day Care, Illinois Department of Children & Family Services, 1993.

Standardizing the Child Care Supply and Demand Information Collected by CCR&Rs: The California Experience

Fran Kipnis, California Child Care Resource and Referral Network

Introduction

The California Department of Education has funded CCR&Rs since 1976. CCR&R services are now available in every county of the state. The primary services offered by CCR&Rs include free referral counseling to all parents, support, training and technical assistance to child care providers, information gathering on local child care supply (child care providers in the service delivery area) and demand (the child care needs of families) and technical assistance to local and state governments and the child care community regarding child care issues.

California, like many other states, has created a statewide CCR&R network to link together its local agencies. Currently 30 states have CCR&R networks in place. The California Child Care Resource and Referral Network (Network) was born in 1980 out of the CCR&Rs' needs to combine their resources and to document and impact child care issues on a statewide level. The Network is funded through CCR&R agency dues, as well as a variety of private, state and federal grants and special contracts. The Network provides information, training, and technical assistance to the R&R agencies, and administers statewide child care projects and research. The Network also works with the child care community on statewide child care planning and advocacy.

Local CCR&Rs collect an enormous amount of data on the supply and demand of child care as a by-product of their primary services. This local supply and demand information assists local governments and the local child care community in the wise distribution of child care resources. There are divergent opinions in the field on the role of CCR&R data collection. Many CCR&Rs collect only the data that flow from the referral process itself, while other agencies collect data for purposes beyond their primary services.

Statewide data collection has proved challenging to many state networks. In California, data collection has historically been locally driven. Because many CCR&RS began operations before the Network was born, and state reporting requirements are minimal, CCR&Rs have developed their data systems to meet the needs of their diverse local communities. As a result, the California Network is currently unable to aggregate child care data regionally and statewide.

This parallels the situation among the states: states have developed their own data collection and reporting requirements based on their needs. At this time, we cannot aggregate this information nationally.

Infrastructure in Place
Child Care Resource & Referral Agencies as Sources of Child Care Data

Although California's CCR&Rs have developed their data systems independently, they have a rich history of joint data collection projects. These projects have moved child care forward in the state, and have paved the way for the current Data Standardization Project.

Building Blocks in California's Data Standardization Project

In 1984, the Network worked with eight Bay area CCR&Rs to create the Child Care Information Kit. CCR&Rs agreed on the standard supply terminology to use in a survey of 4000 child care providers. Combining this supply information, with CCR&R demand information and 1980 census data, the Kit identified a gap of 50,000 child care spaces in the Bay area.

It was a direct result of the Kit that the Bank of American worked with the Network to begin funding the Child Care Initiative Project (CCIP). CCIP, operating in California and replicated in other states, funds CCR&Rs to recruit, train, and retain family child care home providers.

In 1986, California began another major data collection venture. As part of the implementation of the Greater Avenues for Independence (GAIN) program, California's welfare reform program, the State contracted with the Network to conduct an extensive market rate and supply survey of California's licensed providers. GAIN, a precursor to the JOBS program, guaranteed child care support to AFDC parents in job training and search.

CCR&Rs interviewed 35,000 providers across the state. Using the standard terms developed in the Kit, providers were asked about rates, capacity, enrollment, vacancies, waiting lists and hours of care. The state used the survey results to establish the reimbursement ceilings for child care expenses for GAIN clients. Moreover, the state now had the child care supply information needed to plan for the child care needs of GAIN clients. The CCR&Rs' role in the 1986 survey led the way to their role in the current welfare reform movement, of which child care support is an essential element.

In 1988, the Federal Family Support Act implemented national welfare reform and mandated regional market rate (RMR) surveys in every state. California again approached the Network to conduct its annual RMR survey. However, the scope of the new federal RMR survey is much narrower that the original state funded survey. The survey currently collects rate and enrollment data only from a random sample of providers.

It was as a reaction to this loss of updated supply information, and the need for standard statewide data to respond to the increasingly complex child care policy needs, the growing demand for CCR&R services during the 1980's, and the increasing interest in the child care needs of welfare reform, that the California CCR&Rs wanted to improve and standardize their data. The CCR&Rs identified data standardization as a Network priority in 1990. Other states across the county, responding to similar issues, have also embarked on data standardization projects.

Infrastructure in Place
Child Care Resource & Referral Agencies as Sources of Child Care Data

The California R&R Network Data Standardization Project

The original goal of the three-year Project, formulated by the Network Executive Committee was to develop a standard, systematic, statewide data collection and reporting methodology that would:

1) accommodate the diverse manual and computer systems already in place at the local level,

2) enable CCR&Rs to provide quality referrals and ongoing data on child care in their communities, and very importantly,

3) enable the Network to develop and maintain a statewide profile of child care supply and demand.

Making it Happen - The Standardization Process

The Network faced two major challenges at the onset. First, the state was unable to fund the Project, making it necessary for the CCR&Rs to fund the project themselves. Second, the Network is a membership organization, and not a regulatory agency, and thus could not mandate CCR&R participation in the Project. Given these challenges, the Network considered it essential that the Project structure and design accommodate extensive grass-roots CCR&R input and participation. The Project process and outcomes had to meet the needs and realities of the CCR&Rs to make it worth their while to participate.

Step One - Formation of the R&R Network Data Standardization Committee (Committee). Our first step was to convene a Committee of CCR&R staff that would work with the Network to guide and implement the Project. Committee members represent the diversity of CCR&R agencies. All areas of the state are represented, as well as small and large agencies, and agencies using different data files: manual files, locally designed databases, and CareFinder, a custom R&R software program.

Step Two - Developing Baseline Information. The second step was to survey the CCR&Rs to identify the data systems in place. The Committee needed to know what information CCR&Rs were collecting, how they were defining and using their data, the types of data files they were using, and the changes CCR&Rs wanted under the umbrella of the Project. The Network considered this information essential baseline information from which to formulate the possibilities of the Project. The Committee needed to document, then plan!

Step Three - Evaluating the Baseline Information. The Committee found that data collection in the state varied widely from agency to agency. Table I in Appendix A demonstrates the scope of the data collected by local CCR&Rs on the child care providers in their communities. Most agencies collect information on such things as provider location, ages of children served, rates, capacity, and schedule of care.

The Committee found that, while there were certain commonalities, definitions of the data differed. For instance, definitions of *full-time* child care ranged from *four or more hours per week* to *35 or more hours per week.* As Table II indicates, the most common definition used (by 20% of the agencies) is not even a definition. CCR&Rs use the child care provider's own definition of full-time.

Table III shows the flip side – parent requests: the ages of children needing care, the schedule of care needed and the geographic vicinity of care needed. It is by combining this agency supply and demand information that CCR&Rs, on a local level, can evaluate child care supply and demand, an evaluation essential to the wise distribution of local child care funds. However, it was clear that the Network would not be able to combine the information statewide.

The survey also revealed that CCR&Rs use many different data systems - from index cards, to personal computers, to mainframe computers. Computerized CCR&Rs use a variety of software programs. The most frequently used software program was CareFinder, a custom designed child care resource and referral program.

Step Four - Defining Goals through the Focus Group Process. The Committee's fourth task was convening CCR&R focus groups in every region of the state, so that all the agencies could attend. At the Focus Groups, CCR&Rs defined the goals and parameters of the Project and talked about their individual agency's needs.

CCR&Rs clearly stated that they did not want the Project to create entirely new data systems, software or protocols. They outlined four project goals:

1) establish statewide definitions, and statewide data collection and reporting procedures for the data that are essential for understanding the supply and demand of child care in the state,

2) ensure that these standard data flow from the referral process itself,

3) allow CCR&Rs to locally define the data not essential to the Project, and

4) accommodate the diverse data systems in place.

Appendix B documents the results of the Focus Group discussions in more detail.

Step V - Consensus on Data Standards. Developing the standard data collection and reporting procedures has been a long, arduous process. The Committee drafted recommendations for the standard data collection procedures, and presented these recommendations to the CCR&Rs at

Network meetings for comments and suggestions. After many revisions, the Network governing committees unanimously approved the data collection standards displayed in Appendix C and Appendix D. A group of CCR&Rs are currently piloting these standards, before statewide implementation.

Using the Data - Now and the Future

Once CCR&Rs standardize their data collection and reporting, the Network will be able to create a statewide profile of child care supply and demand. The supply profile will describe where licensed care exists, and the number of licensed child care facilities in operation. It also will describe, by age group and schedule of care, total licensed capacity, the number of children enrolled in licensed child care, and the number of unoccupied slots. Also, the profile will show the special schedules of care available at licensed facilities (i.e., weekend and evening care), and the languages spoken by providers when caring for the children. Finally, the profile will describe the types of public subsidies funding child care facilities.

The demand profile will describe parents' requests for child care. This includes where parents are looking for care, the ages of children needing care, the schedules of care needed and the languages parents want providers to speak when working with the children. By combining this supply and demand information the child care community will know how well California's child care supply meets its child care demand. This information is vital to the wise distribution of limited child care resources.

Welfare Reform and CCR&R Participation in Regional Market Rates Surveys[1]

An essential element of the 1988 Federal Family Support Act (FSA) is child care support for participants in the JOBS program, and child care support for one year, for parents leaving AFDC for job related reasons. The FSA increased the minimum child care reimbursements the states previously paid for child care from $160.00 per month to $175.00 per month for children two years and older, and $200.00 per month for children under two. More importantly, it gave the states the option to pay more. The federal government will provide matching funds for states for child care costs up to the 75th percentile of the market rate.

To establish the market rate, the FSA regulations outline a survey methodology for statewide market rate surveys that require the states to interview a valid sample of child care providers. Market rates are to be established for appropriate regions in the state every two years, for different age groups, separately for full-time and part-time care, for different types of providers, and for children with special needs.

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[1] General information regarding the surveys was taken from Nancy Ebb, Children's Defense Fund, *Steps Every State Should Take to Implement the Child Care Provisions of the Family Support Act: A Preliminary Guide to Public Law 100-485*, September 1989.

CCR&Rs played, and continue to play, an important role in market rate surveys. Some states use the rate data collected by the CCR&Rs though their referral process to determine the market rates. Other CCR&Rs design and conduct rate surveys to enhance their referral data. In California, the Network manages the survey. The CCR&Rs provide the Network with their list of child care providers, which is used for the survey sample. CCR&Rs also send letters explaining the survey and encouraging participation to the providers likely to be interviewed.

Using computer assisted telephone interviewing (CATI), California annually contacts 13,000 providers to gather the rate data needed to calculate the market rates. The Network analyzes the data and calculates two reimbursement ceilings: the 75th percentile of the market rate and a reimbursement ceiling at 1.5 standard deviations above the mean market rate, which is generally higher. California will reimburse JOBS participants, and participants in other subsidized child care programs at the higher rate, even thought the federal government only matches the state costs up to the 75th percentile.

The importance of documenting the true cost of child care through well funded and well executed market rate studies are far reaching. Child care advocates believe that even if states cannot reimburse clients at the market rates, states must know the cost of child care. They must understand the likelihood of JOBS clients, and participants in other welfare reform programs, accessing quality child care in a very competitive environment.

Studies document the importance of quality child care in the success of welfare reform. In its study of GAIN clients, the Family Welfare Research Group at the School of Social Welfare, University of California at Berkeley found:

> *the type of care used by parents was not a significant predictor of their success in GAIN, but their satisfaction with that care and the adequacy of convenience and safety were very important to parents continued progress in the program. Parents who were dissatisfied with the provider or facility they were using, were only half as likely to continue in their work preparation activities, and inadequate staffing and poor rating of the safety of care significantly and substantially decreased the odds of their successes.*[2]

The ability to access care that meets a parents' needs is based on many factors, a major one being the ability to purchase the care. We as advocates want to ensure that high quality market rate data are available to the states. This allows states to work toward ensuring that all parents have access to the quality child care they need to move toward self sufficiency.

---

[2] Neil Gilbert, Principal Investigator, *GAIN Family Life and Child Care Study Final Report.*

Appendix A California CCR&R Data Collection on Child Care Providers

Table 1

The Information R&Rs Collect about their Licensed Providers

Provider Information (N=67)	Percentage of R&Rs Collecting the Information
Name of provider	100%
Address of provider	100%
Provider's phone number	100%
Ages of children provider serves	100%
Provider's geographical vicinity (closest school, X-street, etc.)	100%
Rates provider charges	100%
Provider's licensed capacity	100%
Schedule of care provided	100%
Provider's license number	99%
License expiration date	99%
Types of services provided (meals, special needs,transportation, etc.)	97%
Number of vacant spaces	94%
Type of program (Montessori, Child Development, etc.)	93%
Availability of subsidy	87%
Center/home environment (no smoking, pet, yard, etc.)	85%
Auspice of center/home (private for profit, non-profit, etc.)	69%
Qualifications of center/home staff	69%
Center/home accreditation	66%
Adult/child ratio	60%
Eligibility requirement to enroll in center/home	55%
Number of children enrolled	40%
Provider's waiting list	39%

Source: CCCR&R Agency Data Standardization Survey, April 1992.

Appendix A California CCR&R Data Collection on Child Care Providers (continued)

Table 2

Full-Time Definitions Used in R&R Provider Files

Full-time Definition	**Percentage of R&Rs Using Definition**
Provider defined	20%
35 or more hours/week	13%
6 1/2 or more hours/day	12%
32 or more hours/week	8%
30 or more hours/week	8%
8 or more hours/day	5%
5 days/week, or 6 1/2 hours/day	5%
10-12 hours/day	3%
7 or more hours/day	3%
6 or more hours/day	3%
5 days/week, 8 or more hours/day	3%
5 days/week, 8 1/2 or more hours/day	2%
5 days/week, and/or 45 hours/week	2%
5 or more hours/day	2%
4 or more days/week	2%
Other	8%
TOTAL	99% (N=60)

Note: Percentages do not total 100% due to rounding.

Source: CCCR&R Agency Data Standardization Survey, April 1992.

Table 3

The Information R&Rs Collect about Parents

Parent Information (N=67, unless indicated)	**Percentage of R&Rs Coll the Information**
Reason care needed	100%
Name of parent	100%
Age of children needing care	100%
Schedule of care needed	100%
Number of children needing care	100%
Geographical vicinity of care requested	99%
Phone number of parent	99%
Type of provider requested	99%
Address of parent	93%
Employment status of parent	90%
Type of services requested	90%
Student status of parent	84%
Parent eligibility for subsidized care	76%
Type of program requested	70%
Type of environment requested	61%
Relationship of parent to child	48%
Family size	42% (N=55)
Language spoken by parent	39% (N=66)
Family income	37%
Marital status of parent	33% (N=66)
What parent can pay for child care	20% (N=66)
Ethnicity of parent	15%
Age of parent	8% (N=53)

Source: CCCR&R Agency Data Standardization Survey, April 1992.

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Appendix B California CCR&R Agency Data Standardization Focus Groups

California
Child Care
Resource & Referral
Network

February 14, 1992

TO: All Resource and Referral Agency Directors
Members of the Network Data Standardization Committee

FROM: Patty Siegel, Fran Kipnis and Jan Brown

RE: Network Data Standardization Project: R&R Agency Regional Focus Groups

During the months of March and April, the Network will convene four regional R&R agency focus groups to share information and discuss the goals and implementation of the Network Data Standardization Project. This memo will describe the purpose, agenda and logistics of the focus groups.

We are also enclosing a pink RSVP form. **Please return the RSVP form to the Network office by March 1, 1992** so we can confirm the number of people attending each focus group with our focus group sites and caterers.

If you have any questions about the focus groups or the Data Standardization Project, please feel free to call Fran Kipnis at the Network office, (415)882-0234.

Purpose and Agenda of the R&R Agency Regional Focus Groups

The R&R agency regional focus groups are an essential part of the Network Data Standardization Project. The goal of the Project is to develop a uniform method of collecting and reporting child care supply and demand information. We want this method to have local, regional and statewide applicability, and be adaptable to the manual and computer systems already in place in each local R&R agency.

The focus groups will be provide an opportunity for R&Rs to:

1) share information about their parent and provider files,

2) discuss the goals of a uniform method of collecting and reporting child care supply and demand data, and

3) address individual agency's needs in the planning and implementation of this new method of collecting and reporting data.

111 New Montgomery Street, 7th Floor San Francisco, CA 94105 (415) 882-0234 Fax: (415) 882-6233

When thinking about these topics, please focus on the internal needs of your agency, the needs of your local community, and beyond to broader regional and statewide information needs.

To facilitate the focus group discussions, please bring copies of the manual forms and/or print-outs of the computer screens your R&R agency uses for their parent and provider files.

R&R Agency Regional Focus Groups - Logistics

The Network is convening four focus groups around the state. Your agency is invited to attend the one that is most convenient.

R&Rs will be responsible for their travel costs to a focus group, however, a light breakfast and a great lunch will be provided at no cost to R&R agencies.

All focus groups will begin promptly at 10:00 AM and end at 3:00 PM. The locations of the focus groups are listed on the blue sheet attached to this mailing.

We are requesting that the R&R Agency Director and one key staff person (referral counselor or computer specialist, etc.) attend a focus group. If an R&R serves more than one county, we are requesting that in addition to the R&R Director, one key staff person from each county served attend a focus group.

Please return the RSVP form to Network by March 1, 1992, so we can confirm the number of people attending each focus group with our focus group sites and caterers.

We are looking forward to seeing you at the focus groups. Again, please feel free to call Fran Kipnis (415)882-0234 at the Network office if you have any questions about the focus groups or the Data Standardization Project.

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California
Child Care
Resource & Referral
Network

Preliminary Report

May 1992

R&R Agency Regional Data Standardization Focus Groups
March - April 1992

1) At the four Data Standardization Focus Groups, R&Rs agreed that:

   o the Data Standardization Project should establish standard data collection procedures, including standard definitions of child care terms,

   o the standardized system must be adaptable to the various R&R manual and computer systems already in place,

   o standard data collection procedures are necessary for aggregating local R&R data regionally and statewide, and

   o aggregating local R&R data regionally and statewide is essential for analyzing local, regional and statewide trends in child care supply and demand.

2) Many R&Rs reported satisfaction with their data systems in terms of the effectiveness of their child care referrals. However, they want to improve their data systems so that their parent and provider data will be more accessible for reporting purposes. This will allow R&Rs to reduce the time needed to analyze, report and distribute their data to the child care community.

3) R&Rs clearly stated that providing resource and referral services is their primary role, and data collection is a secondary role. R&Rs want to collect data that flow from the referral process, and are directly used for understanding child care needs. R&Rs also stated the need to collect information that might be useful only to their local community.

111 New Montgomery Street, 7th Floor San Francisco, CA 94105 (415) 882-0234 Fax: (415) 882-6233

4) R&Rs reported that they would like training on using their data more effectively, using data from outside sources, particularly the 1990 Census, and making professional child care data presentations to funding sources and the public.

5) R&Rs clearly stated that the Network must provide comprehensive and timely training and documentation on the new data collection procedures established by the Data Standardization Project.

6) R&Rs recommended that a representative group of R&Rs pretest all the new data collection and training procedures before they are implemented statewide.

7) R&Rs also recommended that the Project should give the R&Rs adequate time to implement any changes in data collection procedures, so that implementation can take place within the normal R&R work load. However, there should be a final implementation deadline so that the process does not last indefinitely.

8) The Focus Group evaluations revealed that one of the most useful aspects of the Focus Groups was the opportunity for R&Rs to learn how other R&Rs use their data files. R&Rs hope they can continue to share this information and learn from each other.

Appendix C California Standard Data Collection Procedures: Child Care Provider Data

R&R Network Data Standardization Project Committee

Standard Data Collection Procedures
for
Active, Licensed Child Care Providers

PILOT VERSION

June 1993

Introduction

1) The Data Standardization Project Committee (Committee) is standardizing some of the information R&Rs collect on the providers in their service area. By "standard" we mean that all R&Rs will collect and report this information in the same way. Each piece of standard information on the following chart will be called a "data element".

2) Once R&Rs standardize this information, the Network will be able to aggregate the data elements and create local, regional and statewide reports. These reports will help the R&Rs, the California Department of Education and the child care community better understand the supply of child care in California, and assist in the planning and implementation of child care programs.

3) Collecting these standard data elements does not preclude R&Rs from collecting any additional information, in any format, that is needed to provide high quality child care referrals.

4) The Committee wants the R&R provider files to include all the active, licensed child care centers and family day care homes in the R&R service area. By "active" provider, we mean a provider who is currently serving children, or willing to care for children. We want the R&Rs to use the standard data elements for all these licensed providers, if possible.

5) For those active, licensed providers who do not want referrals and refuse to give all this information to the R&R, we would like the R&Rs to collect, at a minimum, these providers' name, address, phone number, and licensed capacity information.

6) Many R&Rs include licensed-exempt providers in their provider files. We encourage R&Rs to use these standards, when appropriate, for these providers.

7) R&Rs will collect child care provider information by site. If a center has more than one license, because it is licensed to serve more than one age group, the center will be listed only once in the provider file. The multi-license information will be recorded on either the center's intake form, or within the center's record in a computer database.

If a separate agency administers a group of centers, each center will be listed individually in the provider file. Information about the administrative agency can be recorded on either the center's intake form or within the center's database record.

This chart is an outline of the standard data elements. In early 1994, after a comprehensive Project Pilot, Committee will provide in-depth R&R training for collecting and reporting this information.

Definitions of Common Terms

Full time	*35 or more hours per week*
Part time	*Less than 35 hours per week*
Infant	*Under 2-years-old*
Preschool	*Two through 5 years, 11 months*
School age	*Six years and older*

Data Element	Description of Data Element	
Provider name	Family Day Care Home *Write or type in:* The name under "this License to" on the family day care license. If the provider name listed under "this License to" is a facility name, then type in the name of the family day care owner.	Child Care Center *Write or type in:* The "Name of Facility" on the da care center license. Use a unique site identifier if needed. Example: YMCA/Fremont YMCA/Livermore

Location and phone number: *the location of the facility*	Family Day Care Home and Child Care Center *Write or type in:* Location street Location city Location zip code Location area code/phone number
RMR survey address and phone number: *the best place to get information for the RMR survey*	Family Day Care Home and Child Care Center *Write or type in:* Survey street Survey city Survey zip code Survey area code/phone number

Data Element	Description of Data Element
Type of care	Family Day Care Home and Child Care Center *Check one:* Family day care home Child care center
Licensed-exempt: *provider is legally exempt from licensure*	Family Day Care Home and Child Care Center *Check if the provider is licensed-exempt:* ___ Licensed-exempt

Licensed capacity: *the capacity as indicated on the provider's license*	Family Day Care Home *Write or type in:* The total licensed capacity	Child Care Center *Write or type in:* Infant licensed capacity Preschool licensed capacity School age licensed capacity

Data Element	Description of Data Element
Schedule of care available	Family Day Care Home and Child Care Center *Check all that apply:* Full time - 35 hours or more per week Part time - less than 35 hours per week
Special schedule of care available	Family Day Care Home and Child Care Center *Check all that apply:* Evening/no sleepover (all or part of the care shift is after 7PM) Overnight/sleepover Weekends Vacations/holidays/off-track for year round schools Summer only Full year Rotating schedule (child's schedule varies weekly/monthly) Drop-in Before school After school

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Data Element	Description of Data Element
Languages spoken by the provider: *languages spoken by the provider when working with the children*	Family Day Care Home and Child Care Center *Check all that apply:* Spanish Chinese Tagalog Vietnamese Korean
Subsidies available: *direct contract between the provider and a funding source to fund permanent child care slots at the facility*	Family Day Care Home and Child Care Center *Check all that apply:* Head Start contract CDE contract Other public contract - R&R has a direct contract with another public agency, such as a county, city or town to fund child care slots at the facility.

Data Element	Description of Data Element	
Enrollment: *the number of children currently on the provider's registration list*	Family Day Care Home *Write or type in the number:* Infant enrollment Preschool enrollment School age enrollment	Child Care Center *Write or type in the number:* Full time infant enrollment Part time infant enrollment Full time preschool enrollment Part time preschool enrollment Full time school age enrollment Part time school age enrollment
Vacancy: *the number of children, in addition to those currently enrolled, that the provider is willing to care for, within the provider's licensed capacity*	Family Day Care Home *Write or type in the number:* Full time vacancy Part time vacancy	Child Care Center *Write or type in the number:* Full time infant vacancy Part time infant vacancy Full time preschool vacancy Part time preschool vacancy Full time school age vacancy Part time school age vacancy

****** OPTIONAL ELEMENT ******

Data Element	Description of Data Element
Rates	Family Day Care Home and Child Care Center *Write or type in the rate the provider charges in dollars and cents:* Full time infant rate and rate unit Part time infant rate and rate unit Full time preschool rate and rate unit Part time preschool rate and rate unit Full time school age rate and rate unit Part time school age rate and rate unit

Appendix D California Data Collection Procedures: Parent Data

R&R Network Data Standardization Project Committee
Standard Data Collection Procedures
for
Parents Requesting Child Care Referrals

PILOT VERSION

June 1993

Introduction

1) The Data Standardization Project Committee (Committee) is standardizing some of the informatio R&Rs collect on parents requesting child care referrals. By "standard" we mean that all R&Rs wi collect and report the information in the same way. Each piece of standard information on th following chart will be called a "data element".

2) Once R&Rs standardize this information, the Network will be able to aggregate the data element and create local, regional and statewide reports. These reports, combined with outsid demographic data, will help the R&Rs, the California Department of Education and the child car community better understand the demand for child care in California, and assist in the plannin and implementation of child care programs.

3) Collecting these standard data elements does not preclude R&Rs from collecting any additiona information, in any format, that is needed to provide high quality child care referrals.

4) The Committee wants the R&R parent files to include all the parents telephoning or dropping-i to the R&R requesting child care referrals. This includes parents requesting referrals whos referrals are paid for by:

A CDE contract, or
An employer contract, or
An other special contract between an agency and the R&R.

5) We understand however, that some R&R agencies, because of their organizational structure or internal policies will be unable to do this. At a minimum, we are requesting that R&Rs use these standards for parents requesting child care referrals whose referrals are paid for by a CDE Resource and Referral contract.

6) We are still in the process of developing standard procedures for call-backs - parents who call the R&R back for additional referrals.

This chart is an outline of the standard data elements. In early 1994, after a comprehensive Projec Committee will provide in-depth R&R training for collecting and reporting this information.

Data Element	Description of Data Element
Type of referral: *funding source for the referral*	*Check one:* CDE referral Employer referral Other referral for a special R&R contract - such as a GAIN referra for by the county
Reason care is requested	*Check all that apply:* Employment Looking for work In school/training Other parental needs - the parent is not available to care for the chi reasons other than working, looking for work, or school/training. CPS/respite - the parent is referred by CPS or by another professio child care Alternate/back-up care - the parent needs back-up care because his/ regular child care arrangement is unavailable. Mildly ill child care - the child is ill and cannot attend school or his/ usual child care arrangement. Enrichment and/or developmental - the parent is available to care f child, but wants the child to attend child care for the child's enrichm development.

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Data Element	Description of Data Element
Languages requested: *languages the parent wants the provider to speak when working with the children*	*Check all that apply:* Spanish Chinese Tagalog Vietnamese Korean
Number of children needing care	*Write or type in:* The number of children needing care
Age of child when care is needed	*Write or type in:* The age of the child in years and months *This information is collected for each child needing care.*
Kindergarten: *the child will be in kindergarten when care is needed*	*Check if the child will be in kindergarten when care is needed:* ___ Kindergarten *This information is collected for each child needing care.*
Special needs: *special needs will be defined per the American with Disabilities Act*	*Check if the parent is looking for care for a child with special needs.* ___ Special needs *This information is collected for each child needing care.*

Data Element	Description of Data Element
Where care is requested	*Check all that apply:* Near child's home Near child's school Near parent's workplace *This information is collected for each child needing care.*
Type of care requested	*Check all that apply:* Child care center Family day care home In-home care Other *This information is collected for each child needing care.*

Data Element	Description of Data Element
Schedule of care requested	*Check all that apply:* Full time - 35 or more hours per week Part time - less than 35 hours per week
Special Schedule	*Check all that apply:* Evening/no sleepover (all or part of care shift is after 7PM) Overnight/sleepover Weekends Vacations/holidays/off-track for year round schools Summer only Full year Rotating schedule (child's schedule varies weekly/monthly) Drop-in Before school After school *This information is collected for each child needing care.*

****OPTIONAL ELEMENTS****

Data Element	Description of Data Element
Teenage parent: *parent is under 20-years-old*	*Check if the parent is under 20-years-old:* __ Parent under 20
Parent potentially eligible for child care subsidy	*Check if the parent is potentially eligible for child care subsidies:* __ Potentially eligible for subsidy A parent is potentially eligible for subsidy if his/her income level, based o family size, meets the eligibility requirement for any state or federal child care subsidy program. If the referral counselor cannot determine this, then the Project will define a parent as potentially eligible for subsidy if s/he requests subsidy information after learning about the availability of subsidy programs for low-income parents.

Infrastructure in Place
Child Care Resource & Referral Agencies as Sources of Child Care Data

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Child Care Resource and Referral: Linking with Other Systems in Maryland

Sandra Skolnik, Maryland State Child Care Resource Network

Introduction

Families from all socioeconomic and ethnic backgrounds who live in Maryland benefit from a well-developed child care system. By linking child care providers, parents, public policy officials, licensing agencies, businesses, and other community groups, families can expect more responsive, quality child care which meets a variety of needs. This has been accomplished through the efforts of a network of child care resource centers called the Maryland Child Care Resource Network.

Background

In 1988, a group of top business and labor leaders recognized the connection between a strong child care system and Maryland's continued economic development. The Maryland Employers Advisory Council on Child Care (MEACCC) was developed to formulate strategies to improve the child care system in Maryland. MEACCC's members looked at child care delivery across the state as a distinct business system, analyzed its strengths and weaknesses, and ultimately, called for the creation of a public-private partnership (the Maryland Child Care Resource Network) to provide the necessary infrastructure of supports.

The primary goal of the Network as proposed by MEACCC is to improve and expand the child care statewide through a wide array of services which have been documented to strengthen child care. The Network's design encourages the active and collaborative involvement of its *shareholders* in the development of an improved system.

Structure and Composition of the Network

The Maryland Committee for Children (MCC) is a private, non-profit child advocacy organization operating since 1945. MCC was identified, through a request for proposals process administered by the Maryland Department of Human Resources, to be the operator of the Statewide Child Care Resource Center within the Network.

Three regional child care resource centers are located in geographically representative areas (urban, rural, and suburban). The Statewide Child Care Resource Center has created an Advisory Board of child care professionals, educators, regulators, and advocates. Each regional child care resource center has a Board of Directors (or Advisory Board, dependent on organizational structure) which performs a similar regional function. Resource centers also have other advisory groups which relate to specific service programs (e.g. parent counseling and referral, training, etc). Chairpersons of regional child care resource center boards serve on the Network Board which is primarily comprised of business leaders and which functions to provide program guidance and raise funds to support the project.

Services Provided

Each regional child care resource center and the statewide resource center serve specific geographic areas; the statewide resource center serves counties where a child care resource and referral service is not present. Each provides services to parents, child care providers, and employers.

The programmatic departments include LOCATE: Child Care, a child care resource and referral service designed to help families identify quality child care, evaluate child care options, and address child development issues.

TECHNIC: Child Care is a technical assistance service available to current and prospective child care professionals and employers considering work/family options. The Network has developed resources and interactive training on marketing, licensing, and business issues.

Training services are also available to both parents and child care professionals. The Training Departments focuses on child development and programmatic issues; workshop modules are designed to enhance the quality of child care and are based on the needs of the community.

Public Education incorporates data and information gathered from all departments and shares data with legislators, advocates, parent groups, provider associations, and the private sector. The knowledge gained from data analysis of service delivery is critical to the public policy efforts of the state.

Data Collection by a State Network

The application of data is highly dependent upon its potential uses, how information is defined over time, and its general accuracy. The Maryland Child Care Resource Network, through planning and communication, has established frequent and routine evaluative measures to ensure high quality and reliable data collection based on defined uses.

Determining Data Sets

Data documented by the Network serves to track the issues of interest and concern at the state and local levels, as well as to provide accountability to the project's funders.

For the Network, uses of data include policy and public education around quality of child care, wages of child care workers, needs of children with special needs, and affordability issues, to name a few. Other uses center around the delivery of services -- including identifying the need for child care based on the available supply, linking families with options which meet their locational, financial, and child development needs, and enhancing the professional development of early childhood professionals. Lastly, for evaluative purposes, the Network monitors levels of service, usage of services, and critical outcomes from services.

Some examples of the hundreds of data sets collected by the Network include:

- child care supply and demand;
- cost of care;
- level of training of child care workers;
- demand for children with special needs; and
- the number of child care slots created by region and by type of care.

A regular review process by the Network provides a fresh perspective on the continued data needs for all *shareholders*.

Defining Data Sets on a Consistent Basis Across the State

From the outset, a task of the Network was to establish consistent definitions for every data element collected by the Network. This commonality of definition ensures integrity of the data collected and is fairly unique in the field.

Each programmatic department of the Network's regional centers and the statewide center collects a variety of statistics on a daily basis, compiling and aggregating them each month. Network staff review programs frequently and routinely, using methods including, but not limited to, departmental meetings at each regional center and by programmatic department across the Network, monthly data collection, and yearly goal setting, again by resource center and by program. MCC's Annual Report documents the Network's progress and is available to its funders.

Some examples of LOCATE department statistics include:

- number of child care programs by type of care;
- cost of care by type of program;
- number of infant slots;
- number of providers/programs added or deleted from the database;
- number of calls and children using LOCATE; and
- general follow-up information including if care was found, type of care.

Additional data collection includes a periodic LOCATE salary survey of all family child care providers and center directors to determine average salary and benefits of child care workers. LOCATE tracks cost of care on a monthly basis, and provides the state with monthly information on the cost of regulated child care (mean, median, and 75th percentile) in order to determine current local market rates and to comply with federal reporting requirements (see Appendix A).

Among the data the TECHNIC departments record is the number of callers requesting technical assistance, slots created with assistance from the TECHNIC staff, and the number of technical training programs offered along with number of participants. TECHNIC departments also collect data to address child care supply and demand, which is integrated with demographic data on a statewide and local basis in order to assess expansion needs.

Training departments report the number of sessions convened and co-sponsored broken down by audience type and the number of participants broken down by type (provider or parent, for example). Every family child care provider and child care center director has been surveyed by the appropriate regional or state Training department to determine training needs.

Testing Accuracy of Data Collection -- Consistency in Interpretation

To remain consistent in the collection of information, each staff person participates in department-specific trainings upon hire. Next, through regular collection and review of data, consistency is monitored at the local and state levels. Core data sets as defined do not change but interpretation can, so within each department, supervisors review definitions at regular intervals. In addition, staff at all levels are involved in data quality assurance.

Sources of Data

The Maryland Child Care Resource Network receives its *core* data on regulated child care providers from the state regulatory office, the Department of Human Resources' Child Care Administration (CCA). Once someone receives a license or registration to operate a child care facility, CCA forwards documentation verifying licensing status and includes name, address, phone number, licensed capacity (by age where applicable), and hours of service. When a licensing status changes, an individual moves, capacities are changed, or other elements change, CCA also forwards this information to the Network office.

In addition to data gathered from CCA, the Head Start grantees forward information on operating facilities.

Each regional office has ongoing relationships with providers; child care providers regularly update the *enhanced* data captured by the Network. The enhanced data include fees for service, meals provided, credentials, additional services, information on the type of environment (e.g. no smoking), and more. Head Start delegates also work with each regional and state center to update the *enhanced* data.

The Network also captures demand data. The Network's LOCATE departments talked to almost 50,000 callers between September 1990 and May 1993. From the counselors' discussions with parents, the Network captures the following types of demand data:

- what type of child care parents are looking for;
- what is desirable in a program;
- what is affordable;
- reasons care is needed;
- level of satisfaction with care selected;
- data from both subsidized and nonsubsidized families; and
- data on programs that cut across state departmental turf.

Appendix B shows how these various type of data are captured and used by the Network. CCR&Rs are in a unique position to provide policy planners both supply/demand data and trend analysis regarding child care.

Key Projects in Maryland

State Network Role in Market Rate Analysis

The Child Care and Development Block Grant required states to develop a market rate survey to justify spending under the funding stream. Because Maryland had a CCR&R system with a statewide database, Maryland was the only state that did not have to survey the child care community manually to report to the federal government on the median, mode, and 75th percentile of market rate and population.

As Appendix A shows, the Maryland Child Care Resource Network can document regionally by age of child and by type of provider the mean, median, 75th percentile, percent of state population, and the number of facilities serving the age group. Also included are rates for school age child care.

Enhanced CCR&R for JOBS Clients

The State of Maryland has contracted with two CCR&Rs in the Network to provide enhanced counseling to clients who participate in the JOBS program. By receiving enhanced counseling, child care as a barrier to success in JOBS is eliminated. Clients no longer have the worry of identifying regulated child care options. In the past, the typical client selected unregulated care thinking it was the only resource available, while at the same time, expressing the desire to have their children ready for school.

Enhanced counseling provides clients with a variety of supports. Clients receive extensive counseling on the child care options, readable materials on how to select quality child care, trainings on choosing child care, lists of regulated providers who have confirmed vacancies, and check-in calls from parent counselors providing support during and after the selection process. Many times, the parent counselors are providing case management as well. For all clients, 100% follow-up is performed and documented. Data are available which demonstrate the success of the programs.

CCR&Rs as Head Start Delegates

The Baltimore City Child Care Resource Center (BCCCRC) is a new delegate under the Head Start Administration for Baltimore City. As such, the BCCCRC will manage six Head Start classrooms in the six different child care centers located in the inner city. The projected number of children to be served by this project is 102 (17 children per center site).

The program is on a 46 week, five days per week, 6 hours per day schedule. Each of the teachers in the classroom will be expected to have a bachelor's degree in early childhood education or a related field with experience in working with disadvantaged populations. There will be a teacher and an aide at each site with support services from a director, a secretary, an education coordinator, and two family services coordinators. It is expected that this project will begin in late September or early October.

CCR&Rs Responding to Changing Data Requirements at the Federal Level

As federal agencies are grappling with the myriad of welfare reform issues, the quest for data is ever changing. If or when state governments do not have what the Fed is looking for, they are turning in ever-increasing numbers to local CCR&Rs for the answers. CCR&Rs are unparalleled in their resourcefulness and responsiveness to data needs of the public and private sector. Because CCR&Rs are in a unique position of constant communication with parents and providers, they are the logical source for sensitive information, from both survey instruments and routinely maintained databases, that might not be given to government agencies.

Conclusion

The convincing case to improve child care can only be made by providing decision makers with reliable, compelling data that validates need. Concentrating on solid facts and figures is essential to building a case to improve, enrich, and expand resources for families and young children. The Maryland Child Care Resource Network makes a priority of having and disseminating that information -- not for its own sake, but for the sake of the change which is possible.

With this information, effective programs can be developed, old ones retooled, and duplication of effort can be avoided. These figures are crucial in supporting the efforts not only of the Network, but of other groups concerned with making a difference in the lives of children and families.

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Appendix A Market Rates for Full-Time in Maryland, June 1993

MARYLAND COMMITTEE FOR CHILDREN
FULL-TIME COST OF CARE
JUNE, 1993

Region I - Allegany, Garrett, Washington

Type Care = SMG	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	76.50	76.50	57.50	57.50	57.50	57.50	0.00	0.00	0.00
Median	76.50	76.50	55.00	55.00	55.00	55.00	0.00	0.00	0.00
75th %	76.50	76.50	55.00	55.00	55.00	55.00	0.00	0.00	0.00
% pop	33.33	33.33	100.00	100.00	100.00	100.00	0.00	0.00	0.00
Number	1	1	3	3	3	3	0	0	0

Type Care = CEN	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	91.79	91.79	64.51	61.82	61.36	61.00	58.90	38.07	45.20
Median	85.00	85.00	60.00	61.25	60.00	60.00	60.00	29.38	38.75
75th %	90.00	90.00	67.50	62.50	62.50	62.50	62.50	50.00	60.00
% pop	18.92	18.92	62.16	78.38	81.08	83.78	54.05	29.73	45.95
Number	7	7	23	29	30	31	20	11	17

Type Care = FAM	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	68.94	67.72	63.74	63.11	62.78	62.70	62.55	35.07	51.89
Median	70.00	67.75	65.00	65.00	65.00	60.00	60.00	30.00	55.00
75th %	75.00	75.00	70.00	67.50	67.50	65.25	65.00	40.00	60.00
% pop	62.03	67.27	76.27	77.91	77.91	76.60	68.58	21.60	23.73
Number	379	411	466	476	476	468	419	132	145

Region II - Caroline, Dorchester, Kent, Queen Anne's Somerset, Talbot, Wicomico, Worchester

Type Care = SMG	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	0.00	0.00	40.00	40.00	40.00	40.00	40.00	0.00	0.00
Median	0.00	0.00	40.00	40.00	40.00	40.00	40.00	0.00	0.00
75th %	0.00	0.00	40.00	40.00	40.00	40.00	40.00	0.00	0.00
% pop	0.00	0.00	20.00	20.00	20.00	20.00	20.00	0.00	0.00
Number	0	0	1	1	1	1	1	0	0

Type Care = CEN	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	79.92	76.61	61.19	60.28	61.02	61.33	69.18	31.25	58.27
Median	80.85	80.85	60.00	60.00	60.00	60.00	65.00	30.63	57.50
75th %	85.00	85.00	70.00	68.00	68.00	70.00	70.00	35.00	65.00
% pop	10.77	13.85	63.08	64.62	63.08	60.00	33.85	23.08	16.92
Number	7	9	41	42	41	39	22	15	11

Type Care = FAM	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	62.78	62.48	58.48	58.20	58.09	57.68	57.38	31.69	45.77
Median	60.00	60.00	60.00	60.00	60.00	60.00	55.00	30.00	50.00
75th %	65.00	65.00	60.00	60.00	60.00	60.00	60.00	35.00	55.00
% pop	61.65	64.52	66.79	66.79	66.43	64.76	57.23	27.72	29.51
Number	516	540	559	559	556	542	479	232	247

Key: SMG - Small Group CEN - Center Program FAM - Family Day Care

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Region III - Carroll, Cecil, Frederick, Harford

Type Care - SMG	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	110.00	110.00	75.00	73.75	73.75	66.67	77.50	45.00	80.00
Median	70.00	70.00	60.00	60.00	60.00	55.00	60.00	45.00	80.00
75th %	70.00	70.00	90.00	90.00	90.00	60.00	60.00	45.00	80.00
% pop	40.00	40.00	80.00	80.00	80.00	60.00	40.00	20.00	20.00
Number	2	2	4	4	4	3	2	1	1

Type Care - CEN	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	117.60	118.00	83.38	81.27	80.79	80.03	83.77	46.55	74.71
Median	121.50	118.00	82.75	80.00	80.00	78.00	80.00	45.00	73.00
75th %	125.00	130.00	95.00	90.00	90.00	90.00	90.00	51.00	80.00
% pop	5.56	6.67	63.33	64.44	65.56	62.22	44.44	31.11	26.67
Number	5	6	57	58	59	56	40	28	24

Type Care - FAM	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	84.51	83.28	76.55	75.78	75.33	74.70	73.44	40.15	60.87
Median	85.00	80.00	75.00	75.00	75.00	75.00	75.00	40.00	60.00
75th %	95.00	95.00	85.00	85.00	85.00	84.60	80.00	50.00	75.00
% pop	50.07	54.77	58.72	59.26	58.81	56.89	48.40	27.11	20.40
Number	1014	1109	1189	1200	1191	1152	980	549	413

Region IV - Calvert, Charles, St. Mary's

Type Care - SMG	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	97.50	93.33	72.33	67.33	67.33	67.33	65.00	40.00	0.00
Median	95.00	90.00	68.50	65.00	65.00	65.00	65.00	40.00	0.00
75th %	95.00	95.00	72.00	65.00	65.00	65.00	65.00	40.00	0.00
% pop	18.18	27.27	27.27	27.27	27.27	27.27	18.18	9.09	0.00
Number	2	3	3	3	3	3	2	1	0

Type Care - CEN	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	112.20	109.70	76.01	73.74	73.47	71.51	74.73	49.43	71.87
Median	110.00	100.00	76.00	74.50	74.50	69.00	75.00	49.00	65.00
75th %	125.00	125.00	85.00	80.50	80.00	78.00	80.00	55.00	85.00
% pop	15.63	15.63	57.81	57.81	57.81	57.81	34.38	32.81	23.44
Number	10	10	37	37	37	37	22	21	15

Type Care - FAM	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	83.64	81.83	73.76	72.81	71.98	71.18	70.04	41.74	58.27
Median	85.00	80.00	75.00	75.00	75.00	75.00	70.00	40.00	55.00
75th %	95.00	90.00	80.00	80.00	80.00	80.00	75.00	45.00	65.00
% pop	47.36	48.65	51.24	51.46	51.02	49.19	45.85	33.12	25.78
Number	439	451	475	477	473	456	425	307	239

Region V - Baltimore City, Baltimore, Anne Arundel, Howard, Montgomery, Prince George's

Type Care - SMG	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	170.95	170.95	111.53	111.31	111.06	85.93	67.63	46.20	60.83
Median	171.08	171.08	114.71	114.71	114.71	86.93	66.48	45.00	45.00
75th %	171.08	171.08	114.71	114.71	114.71	86.93	66.48	47.00	80.00
% pop	45.08	45.08	49.84	50.16	49.84	49.52	48.57	3.17	1.90
Number	142	142	157	158	157	156	153	10	6

Appendix A Market Rates for Full-Time in Maryland, June 1993 (continued)

Type Care = CEN	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	142.87	137.50	85.44	83.24	82.96	82.86	82.05	51.67	71.84
Median	137.75	135.00	81.00	80.00	80.00	80.00	80.00	50.00	72.50
75th %	160.00	154.00	92.00	90.00	90.00	90.00	90.00	60.00	80.00
% pop	9.16	10.47	73.64	78.50	78.32	75.14	45.23	34.39	20.37
Number	49	56	394	420	419	402	242	184	109

Type Care = FAM	0-12	13-24	2 yrs	3 yrs	4 yrs	5 yrs	6 yrs	Before/After School Weekly	Before/After Kindergarten Weekly
Mean	96.12	94.27	84.86	83.95	83.25	79.99	76.20	45.89	62.78
Median	90.00	90.00	80.00	80.00	80.00	80.00	75.00	45.00	60.00
75th %	117.63	110.00	100.00	100.00	100.00	85.00	85.00	50.00	75.00
% pop	52.50	55.47	60.18	60.29	58.96	54.89	45.30	23.10	13.58
Number	4029	4257	4619	4627	4525	4213	3477	1773	1042

Key: SMG - Small Group CEN - Center Program FAM - Family Day Care

July 1993: Sample Quarterly Report Based on CCR&R Data Collection

CHILD CARE IN MARYLAN

LOCATE: CHILD CARE DATABASE INFORMATIO

MARYLAND CHILD CARE RESOURCE NETWOR

The Maryland Child Care Resource Network is a public/private partnership designed to expand and improve child care delivery across the state. The Maryland Committee for Children, Inc. (MCC) is a private, non-profit organization which, since 1945, has been an advocate for children and their families. MCC works to improve the quality of early educational opportunities, to increase the availability of child care throughout Maryland, to help parents identify child care programs for their family, and to assist employers in the development of supportive work/family policies, and to speak out on matters of public policy for those who are too young to speak for themselves.

PROGRAMS

JURISDICTIONS	TOTAL * GROUP	8-12 HOUR DAY CARE	INFANT DAY CARE	PART-DAY PROGRAM	SCHOOL-AGE DAY CARE	NURSERY SCHOOL	KINDER-GARTEN	HEAD START	FAMILY DAY CARE
ALLEGANY	18	12	0	6	8	3	3	3	129
ANNE ARUNDEL	147	84	11	38	93	25	19	3	997
BALTIMORE CITY	280	143	19	42	109	25	29	41	1175
BALTIMORE	260	132	14	62	161	29	44	8	1695
CALVERT	33	26	5	6	13	5	4	3	188
CAROLINE	11	7	3	2	7	0	0	2	121
CARROLL	55	26	5	16	28	4	3	4	539
CECIL	17	12	0	3	8	2	3	2	200
CHARLES	52	33	6	9	30	1	1	3	421
DORCHESTER	13	6	1	3	7	2	2	2	78
FREDERICK	70	33	3	18	39	5	4	5	696
GARRETT	16	9	6	2	7	0	0	7	48
HARFORD	50	24	3	11	29	7	3	2	578
HOWARD	103	47	11	23	58	26	14	4	855
KENT	9	5	1	3	2	1	1	2	51
MONTGOMERY	385	218	22	37	165	108	76	48	1780
PRINCE GEORGES	206	166	20	32	91	29	25	11	1732
QUEEN ANNES	15	6	0	3	11	2	0	1	125
ST. MARYS	25	16	3	3	11	2	1	1	315
SOMERSET	9	4	0	0	2	1	0	3	41
TALBOT	12	8	2	3	9	1	2	2	88
WASHINGTON	45	20	4	9	28	5	7	6	426
WICOMICO	26	19	1	3	11	3	3	1	225
WORCESTER	16	12	0	1	4	1	1	3	82
TOTAL	1873	1068	140	335	931	287	245	167	12586

* NUMBERS DO NOT TOTAL BECAUSE FACILITIES MAY HAVE MORE THAN ONE TYPE OF PROGRAM.

7/93

• SUMMER 1993 • 608 WATER STREET • BALTIMORE, MARYLAND 21202 • (410) 752-7588 •

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WEEKLY COST OF CHILD CARE

Jurisdictions	FAMILY DAY CARE 0-2 years Average	FAMILY DAY CARE 2-5 years Average	FAMILY DAY CARE School-Age Average	CENTER-BASED CARE 0-2 years Average	CENTER-BASED CARE 2-5 years Average	CENTER-BASED CARE School-Age Average
ALLEGANY	$ 69.16	$ 64.85	$64.65	-	$ 61.49	$57.29
ANNE ARUNDEL	$ 94.49	$ 81.76	$78.69	$139.94	$ 85.58	$85.27
BALTIMORE CITY	$ 79.69	$ 71.61	$70.22	$128.67	$ 78.76	$74.27
BALTIMORE	$ 93.78	$ 84.25	$80.20	$134.70	$ 82.46	$79.56
CALVERT	$ 88.06	$ 76.40	$74.76	$113.50	$ 70.68	$67.17
CAROLINE	$ 57.72	$ 54.92	$54.23	$ 85.57	$ 63.33	$67.08
CARROLL	$ 83.69	$ 74.82	$72.45	$109.17	$ 79.11	$85.58
CECIL	$ 74.76	$ 66.20	$65.54	-	$ 56.88	$65.00
CHARLES	$ 88.16	$ 75.95	$72.23	$111.73	$ 78.64	$80.43
DORCHESTER	$ 56.09	$ 53.66	$52.43	$ 76.50	$ 54.17	$54.17
FREDERICK	$ 87.42	$ 78.44	$76.33	$123.67	$ 87.53	$86.33
GARRETT	$ 64.52	$ 60.84	$60.70	$ 80.80	$ 57.98	$58.88
HARFORD	$ 85.38	$ 77.00	$74.24	$118.33	$ 81.59	$81.00
HOWARD	$117.33	$100.33	$94.65	$167.27	$100.75	$94.10
KENT	$ 61.54	$ 57.44	$57.13	$ 85.00	$ 61.67	$65.00
MONTGOMERY*	$117.63	$ 98.79	$65.24	$171.08	$107.77	$66.48
PRINCE GEORGES	$ 88.69	$ 78.53	$72.95	$137.76	$ 83.63	$82.26
QUEEN ANNES	$ 70.46	$ 65.66	$64.57	-	$ 69.33	$68.83
ST. MARYS	$ 71.42	$ 65.31	$64.31	$ 82.50	$ 64.05	$61.25
SOMERSET	$ 57.81	$ 53.70	$52.89	-	$ 60.00	$60.00
TALBOT	$ 63.33	$ 62.17	$62.30	$ 88.33	$ 77.00	$82.00
WASHINGTON	$ 68.57	$ 62.92	$62.35	$105.00	$ 60.46	$58.33
WICOMICO	$ 62.07	$ 55.64	$55.12	-	$ 55.54	$70.00
WORCESTER	$ 66.57	$ 62.01	$60.23	$ 35.00	$ 52.64	$80.00
STATE AVERAGE	$ 88.57	$ 78.04	$72.84	$153.09	$ 85.00	$75.85

*DATA PROVIDED BY THE MONTGOMERY COUNTY WORKING PARENTS ASSISTANCE PROGRAM, JULY, 1992, AND CHILD CARE CONNECTIONS.

7/93

The state average for full-time child care for 0 - 5 year olds is $101.18 per week or $5,261.10 per year.

SALARIES AND BENEFITS OF CHILD CARE WORKERS

SALARIES:

JOB TITLE	AVERAGE	HOURLY WAGE
DIRECTOR	$19,094	$9.18
SENIOR STAFF/TEACHER	$13,229	$6.36
AIDE	$10,400	$5.00
FAMILY DAY CARE PROVIDER*	$10,753	

BENEFITS:

TYPE OF CARE	HEALTH INSURANCE	VACATION & SICK DAYS
CENTER	11.3% fully paid 21.4% partially paid	73.2% offer paid vacation 63.9% offer paid sick days
FAMILY DAY CARE PROVIDER	2.4% paid through business	27.4% have paid vacation 23.9% have paid sick days

*1989 Statewide Survey of Family Day Care Providers.

Source: 1991 Random Sample Statewide Salary & Benefits Survey by the Salaries Task Force of the Maryland Committee for Children's Public Policy Committee.

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INFANT CHILD CARE

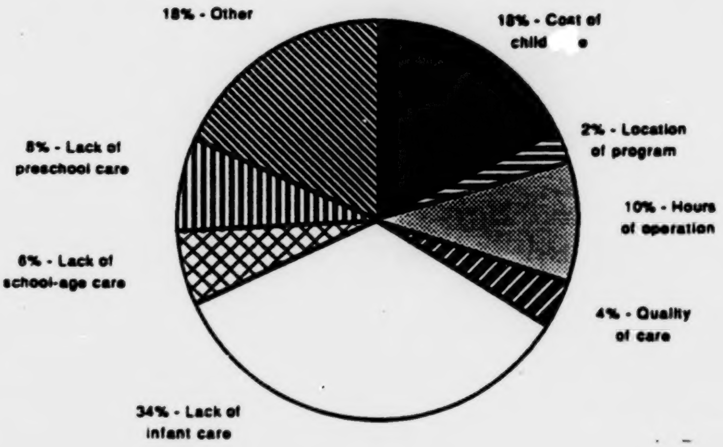
JURISDICTIONS	FAMILY DAY CARE PROVIDERS WILLING TO TAKE CHILDREN UNDER THE AGE OF TWO		GROUP INFANT PROGRAMS WILLING TO TAKE CHILDREN UNDER THE AGE OF TWO	
	0-12 MONTHS	13-23 MONTHS	TOTAL PROGRAMS	TOTAL CAPACITY
ALLEGANY	76	80	0	0
ANNE ARUNDEL	571	603	11	281
BALTIMORE CITY	712	765	19	353
BALTIMORE	1007	1071	14	246
CALVERT	100	101	5	33
CAROLINE	61	63	3	50
CARROLL	275	308	5	43
CECIL	117	125	0	0
CHARLES	195	202	6	36
DORCHESTER	38	40	1	12
FREDERICK	354	389	3	15
GARRETT	27	29	6	28
HARFORD	264	283	3	18
HOWARD	469	479	11	174
KENT	42	42	1	3
MONTGOMERY*	1143	1143	22	284
PRINCE GEORGES	862	924	20	280
QUEEN ANNES	77	79	0	0
ST. MARYS	142	146	3	15
SOMERSET	27	30	0	0
TALBOT	41	43	2	15
WASHINGTON	273	296	4	117
WICOMICO	161	169	1	42
WORCESTER	52	56	0	0
TOTAL	7,086	7,466	140	2,045

*DATA PROVIDED BY CHILD CARE CONNECTION

Although regulations permit infants to be cared for in centers, most infants in regulated child care are in family day care homes. Maryland State Department of Human Resources' regulations require that a family day care provider have no more than 2 children in care under the age of 2, including her own, who are also under the age of 2. 7/93

MAJOR REASONS PARENTS COULD NOT FIND CHILD CARE

(October 1, 1992 - March 31, 1993)



SOURCE: Maryland Committee for Children follow-up calls.

511

CAPACITY

JURISIDICTIONS	FAMILY DAY CARE TOTAL CAPACITY**	CENTER-BASED CARE TOTAL CAPACITY **
ALLEGANY	764	627
ANNE ARUNDEL	6,599	6,372
BALTIMORE CITY	7,292	13,927
BALTIMORE	9,845	11,698
CALVERT	1,187	805
CAROLINE	813	557
CARROLL	3,175	1,988
CECIL	1,276	694
CHARLES	2,477	2,723
DORCHESTER	474	380
FREDERICK	3,785	2,722
GARRETT	311	334
HARFORD	3,433	2,310
HOWARD	4,618	4,913
KENT	340	229
MONTGOMERY	8,627	14,495
PRINCE GEORGES	10,822	10,708
QUEEN ANNES	756	581
ST. MARYS	1,565	739
SOMERSET	275	387
TALBOT	595	606
WASHINGTON	2,610	1,879
WICOMICO	1,187	1,187
WORCESTER	549	638
TOTAL	73,375	81.499

There are 154,874 spaces for children in regulated child care programs in Maryland.

** Providers/programs that were licensed by the Child Care Administration as of May, 1993.

In 1993, 77% of Maryland children under the age of 12 have mothers in the labor force.

- **There are a total of 854,894 Maryland children under the age of 12.**
  - **658,268 of them have working mothers**
  - **196,626 of them have non-working mothers**

Source: Maryland Department of State Planning and LOCATE: Child Care, June 1990.

Funding for this project is provided by the Maryland Committee for Children, Maryland State Department of Human Resources and Baltimore City Department of Social Services.

Program Automation and Integrated Information Systems

Moderated by Sandra L. Brown
Georgia Department of Human Services

Child Support and Automated Information Resources - Christine Kendall and Renate Dauser, Alabama Child Support Enforcement

The Integrated Information System to Support Foster Care - Rami Benbenishty, Ph.D. and Daphna Oyserman, Ph.D., Merrill Palmer Institute, Wayne State University

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Child Support and Automated Information Resources

Christine Kendall and Renate Dauser, Alabama Department of Human Resources

With the implementation of automated systems in the IV-D child support program, many states are finding that they have a wealth of reliable information available to them for the first time. This theme session will focus on the kind of information available in the Alabama system, the utilization of information at the state and local level, and how the information and reports can help planning and projection for future needs.

The Alabama system (Child Support System - CSS) has been in development for several years and was finally brought up in a county by county methodology during 1990 and 1991. All 67 counties were on-line by May 1991. The system operates to both receipt and distribute monies collected at local sites throughout the state. County Human Resources offices and District Attorneys offices involved in the IV-D program are connected to the system.

Through the use of ad hoc reports, the local offices can obtain a picture of their paternity cases, obligations needing establishment, enforcement actions needed, or child support arrearage. This has enabled local managers to pursue special projects such as Father's Day Round-Ups and Parent's Fair Share dockets (AFDC unemployed fathers' dockets). Additionally, the reports have brought a new level of information to local supervisors. In the past, information was maintained through a paper trail. This meant most projections of caseload, needed actions, and even success stories were speculative. With the automated system, the local supervisor/manager is able to clearly demonstrate with very accurate numbers, their caseload, the needs for actions and additional staff, growth in the program, etc.

Additionally, at the state level, the program managers are able to generate information about how many absent parents are state employees, how many absent parents have no Social Security number on the system, what the total amount of arrears owed to the state is and how fast it is growing. One impact of this ability was for tax offset in 1992. As a result of that automated identification, Alabama's collections from that method went from less than $9 million in 1991 to over $21 million in 1992!

Examples of canned reports from the system will be distributed and comments on their utility made. This should he helpful to managers and program planners in the IV-D arena.

For copies of the reports or further information on the system, please contact the presenters (see address list).

The Integrated Information System to Support Foster Care

Rami Benbenishty, Ph.D. and Daphna Oyserman, Ph.D., Merrill Palmer Institute, Wayne State University

The aim of this abstract is to present an Integrated Information System (IIS) for Foster Care. This system makes effective use of information in order to support clinical work, administration, management, licensing and policy making in the area of foster care. The system is designed to provide an integrated response the needs of all partners in the agency, including administrators, managers and policy makers. However, the main focus of the IIS is the information needs of the clinical staff of the agency, caseworkers and clinical supervisors.

The IIS addresses three basic tasks:

- **Monitoring** clients, interventions and outcomes
- **Communicating** within the organization and with other appropriate agencies
- **Learning from experience**, generating knowledge to support effective decision making and planning.

Our methodology calls for monitoring each client unit continuously on an agency wide basis, using shared language, processing information, accumulating a data base for statistical and qualitative analysis and providing feedback on an ongoing basis to all partners.

The Integrated Information System for Foster Care provides:

- Structured and aided information gathering
- Effective information storage and retrieval
- Information processing on many levels
- Immediate reports
- Data transfer
- Continuous statistical analysis

The benefits of the Integrated Information System for Foster Care include:

Assuring quality service delivery

As the system structures data gathering, processing, communicating and reporting, it assures that all professional, legal and administrative directives are being followed. The expertise of the most knowledgeable people in the agency and in the professional literature is embedded in the system and guides practitioners, some of them novice and inexperienced. Changes in policy guidelines and licensing requirements can be immediately incorporated into the system and effect service delivery.

Improving decision making

IIS provides support for decision making on all levels in several ways. The system ensures that all data needed for decisions have been collected properly and communicated to the appropriate decision maker on a timely basis. Further, the IIS can provide an array of decision aids ranging from help screens, access to relevant literature reviews, risk assessment scales, expert system modules, predictive statistical models, and other aids relevant to a specific domain.

Saving time and cutting cost

The information system eliminates redundancies in data collection and reporting. Information items are entered only once and then copied and moved as needed. The time consuming process of report preparation is streamlined and shortened. The need for support staff to type various reports, check for errors and retrieve information from files is reduced significantly.

Providing integration and coordination

The information system provides a means for seamless integration of programs and services. All partners in the agency share the same language and data structures. Information flows among departments and programs and is immediately available for authorized users.

Improving data quality

The information system provides means to ensure the quality and correctness of data at the point of entry. By providing lists, checklists and edit checks, the probability of omissions, contradictions, and typing errors is greatly reduced. Furthermore, because practitioners use the data daily and depend on these data for their work, they pay close attention to the completeness and accuracy of their documentation.

Strengthening reporting and data transfer

Data entered into the system are immediately available to all partners in the organization, cutting the time and effort involved in keeping each of the organization's departments and programs updated. A virtually unlimited number of reports designed to suit the agency needs combined with a flexible and user-friendly report generator, greatly enhance reporting capabilities. The system's ability to transfer data to other information systems is extensive. Data can be transferred electronically using various data formats to fit the characteristics of these related information systems.

Supporting program monitoring and research

The quality, extensiveness and immediate availability of data stored in the system make program monitoring and evaluation, quality assurance and research integral parts of practice and of policy making. In addition, the information system can serve as a platform for data collection efforts needed for research and other purposes such as program development or funding acquisition. For instance, a questionnaire may be added for a limited time to assess the need for a new service.

This comprehensive system is presently designed for personal computers (PCs), programmed in Clipper, and uses a series of additional developing tools and libraries. It is being implemented in Lutheran Child and Family Service of Michigan. We expect to continue developing the system so that it will connect several foster care providers with the Michigan Department of Social Services, allowing for multiple and different computer platforms using the same software.

The conceptual framework and methodology utilized in the current system for foster care can be easily adapted to suit the needs of other child and family programs and to improve integration among service delivery systems. Of particular interest to us currently are Child Protective Services, family preservation, youth residential care, and adoption programs.

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Integrated Information Systems:
A Conceptual Framework for Human Service Organizations

In recent years there has been a growing emphasis on accountability in the human services. Concerns about accountability have permeated attempts to improve effectiveness and efficiency of practice through such methods such as single case design, evaluation research, effectiveness research, management information systems, clinical information systems, integration of research and practice, decision support and expert systems (Bloom & Fischer, 1982; Blythe, 1992; Fischer, 1978; Gingerich 1990; Grasso & Epstein, 1989; Hudson & Nurius, 1993; Jayaratne & Levi, 1979; Kratochwill, 1978; Poertner & Rapp, 1987; Tripodi, 1992; Wich & Schoech, 1988).

Much progress has been made in raising awareness to issues of accountability and the importance of basing practice on empirical evidence of effectiveness. However, less progress has been made in implementing and disseminating effective and accountable practice methods. Practice in human service organizations thus continues to be characterized by the same problems that led to calls for increased accountability and empirically based practice (e.g. Flukes & O'Beirne, 1989; Sicoly, 1989; Mutschler, 1990).

Our analysis of empirical practice, accountability, and integration of research and practice has led us to reframe them as tasks related to information handling. Seen in this light, the mission then becomes one of analyzing information needs of human service organizations and designing appropriate responses to these needs. The challenge is to collect clinically relevant data systematically, process and analyze it in ways that will inform practice, and to fold these insights back into daily practice. Efforts to introduce single subject design, program evaluation and management information systems, can be seen as attempts to address parts of this task of effective use of information. Building on these previous efforts, we have been working for a number of years on a conceptual framework and methodology to address the various aspects of this central concern for human service organizations (Benbenishty, 1989; Oyserman & Benbenishty, 1993).

In this paper we will present a conceptual framework and methodology for the design of Integrated Information Systems (IIS) that aim at providing a more comprehensive response to the information needs of human service organizations than previous efforts described in the literature (Mutschler & Hasenfeld, 1986). We will then describe the elements of the IIS, and briefly review their powerful impact on practice, management and policy making.

Our focus is on the effective use of information to support practice on all levels of the organization. By focusing on information needs of all partners to service delivery we avoid artificially juxtaposing management and direct practice; research and practice; accountability and effectiveness. These unnecessary divisions compartmentalize and divide the field today. Our emphasis on effective use of information to improve practice, directs us to broad scaled analysis of the information needs of each partner in the process of service provision. Thus, within the human service organization, direct clinical staff, supervisors and administrators have information needs, as do licensing and funding agencies which interact with the organization.

Front line clinicians and clients are the most directly involved in information collection and documentation. It is on the basis of this information that each of the other partners receives information necessary to carry out their tasks. Therefore, direct line workers, clients and client groups should a have a major role in determining what information should be collected, processed and disseminated to others. Involvement of these parties and careful consideration of their needs will ensure that clinicians and clients will have a stake at providing timely and accurate information. Hence, some of the thorniest problems of information systems today, namely inaccurate and dated reporting, can be reduced dramatically.

Information Needs

Of the numerous information needs of human service agencies we are focusing on three categories of needs.

1. Monitoring

   This refers to the need to have a "finger on the pulse," to know what is currently happening in the agency. Monitoring addresses the client population, services and interventions provided, and the outcomes of these services (Benbenishty, 1985; Benbenishty & Oyserman, 1991; Oyserman & Benbenishty, 1993). In the present context it is important to point out that direct service staff, supervisors, administrators and policy makers need to use information to monitor issues of relevance to them. Direct service staff need to monitor their clients, supervisors need to know about specific clients and have a picture of whole case loads, administrator need to monitor clients and interventions, and policy makers need to monitor key characteristics of the population and of services provided. Throughout the service delivery process, program compliance, process and outcome quality should be continuously monitored by staff at all levels.

2. Communication

   This refers to the need to share information both within the human service organization, and between related service providers. Human service organizations depend on the cooperation and joint efforts of many individuals, programs and departments. To provide quality care, direct service staff are dependent on colleagues who provide related services, on administrators, on managers, and on funding agencies. Parallelly, supervisors, mangers and policy makers need to receive accurate and timely information from service staff, as well as disseminate information such as agency directives and policy guidelines back to practitioners.

   Due to the complex interdependency between various human service organizations, there is always the need to share information with appropriate and relevant agencies (provided that confidentiality and client rights are protected). Thus, for example, most foster care agencies deal with clients who have been referred via Protective Services. The information which led to this referral should be communicated to the foster care agency. Children exiting foster care are likely to be referred to residential care and adoption services, as well as to a range of community based programs given continued care responsibilities. In addition, clients are likely to receive services simultaneously from several agencies. Clearly, information gathered over the course of foster care should be communicated to these continued care agencies.

   Furthermore, because human service organizations should be accountable to informal and formal social institutions, they need to provide comprehensive and accurate information. Thus, for instance, an adoption service should be communicating with the court with regard to the placement plan for a specific child and with state authorities with regard to the number of children waiting for placement more than six months. Foster care agencies need to be able to describe the services they provided to promote attainment of a treatment plan, as well as be accountable for the decisions leading up to development of these plans.

3. Learning from experience

This refers to the need to use information effectively in order to learn lessons from accumulated experience and to generate knowledge to guide future actions. Human service organizations operate in environments that are characterized by change and high levels of uncertainty and ambiguity. The current level of knowledge in many areas limits to a great extent the ability to predict the possible impact of various lines of action. Furthermore, much of the operation of service agencies is context-specific and dependent on local conditions, limiting the ability to generalize from the experience of other agencies. For instance, a New York City agency trying to assess the effectiveness of 'meals-on-wheels' program for elderly, may be cautious in accepting conclusions drawn from a study of such a program in rural Idaho. Thus, it is clear that even when valid and generalizable knowledge does exist, human service organizations need to learn their environment in order to adapt and adjust to a fast changing milieu.

The IIS Approach

In order to respond to this array of information needs we have developed a methodology appropriate and relevant to the needs of direct service staff, supervisors, administrators, policy makers, and public interest groups. The rational and details of this methodology were described earlier (Benbenishty, 1985; Benbenishty & Oyserman, 1991; Oyserman & Benbenishty, 1993). The basic principle is that the information needs of the human service organization should be addressed on the agency level, integrating as many information needs and participants as possible. According to this approach, each client is monitored systematically and continuously, on aspects relevant to all partners in the agency, using language and structure shared across the agency. Information gathered is immediately processed, shared and stored, accumulating a dynamic data base that serves to inform practice, enables learning and provides guidelines for future action.

The only feasible way to provide a comprehensive response to the broad and complex information needs discussed is a computerized Integrated Information System (IIS). The specifications, design and implementation of this system should follow very closely the rational and methodology outlined above. In general, the impact of an integrated information system is achieved by improving the gathering, storage, retrieval, processing and the analysis of information. The system serves as a mechanism to connect partners, facilitating communication and knowledge dissemination among all partners in the agency. In the following sections we will review the basic elements of the IIS.

Information gathering

The information gathered by practitioners in service agencies is of crucial importance. This information serves as the basis for numerous judgments and decisions of front line workers, supervisors, administrators and policy makers.

Information gathering in human service organizations is an active, selective and informed process. In addition to receiving information from other sources, practitioners need to initiate information search: ask questions, observe, and scan available documents. Given the enormous amount of potentially relevant information, information gathering should be selective and focused. Thus, important information should not be omitted and superfluous information should not be collected. This active and selective information gathering should be based on professional knowledge. To determine what information is relevant and when, may require high levels of skill and expertise. In fact, effective information gathering may be considered a hallmark of expertise.

Because the front line is where most information is being gathered, the Integrated Information System structures and supports this crucial task at the front line. In this way, the IIS moves expertise to the front line. The implication is that the data gathering component of the IIS should be designed by domain experts who have deep understanding of the needs and requirements of the clinical task at hand. Past efforts to develop information systems for clinical settings have often been crippled when systems analysts and programmers without human service expertise have attempted to define information gathering requirements (Kettelhut & Schkade, 1991).

Assurance of practice standards in information gathering is achieved in several ways. Integrated information systems implement tools, such as forms, screens and checklists, to structure the process and capture all information to meet practice needs, as well as reporting and licensing requirements. Forms, checklists and 'help screens' are designed after a thorough analysis of the expertise elicited from practitioners, supervisors, administrators, policy makers, and, whenever relevant, from clients. Also, the professional literature, policy guidelines, service manuals, and other material are studied to identify relevant and necessary information.

In addition to providing guidance in information collection, the IIS reduces errors. This could be on a simple level of avoiding spelling errors and out-of-range values. Error reduction can address more complicated issues by examining whether information collected is self contradictory, or is at odds with policy guidelines. For instance, in the State of Michigan, policy guidelines for foster care mandate that a child under age 14 should not have a treatment plan of permanent foster care unless this has been specifically cleared with the Department of Social Services. An integrated information system for foster care would provide feedback to workers that their treatment plan is age inappropriate, prompt for corrections, and suggest alternatives.

Information storage

The IIS stores information gathered by members of the service agency so that it can be retrieved and processed. Modern computerized systems offer efficient information storage capabilities that facilitate retrieval and processing. Data are stored in relational data bases that accumulate over time, and allow juxtaposing data from several sources. Integrated information systems should be designed around data bases that are both interrelated and independent. As to interrelatedness, most agencies recognize the need to link data bases and information systems so that they connect between the various components of the agency, and between the agency and other neighboring or superordinate agencies.

Emphasis on interrelatedness overlooks the importance of independence of information systems. Focusing only on interrelatedness stifles attempts to create information systems which suit particular programs. Thus an agency or a State may mistakenly attempt to create one information system to meet the information needs of distinct programs such as foster care, juvenile corrections, and adoptions. A balance between interrelatedness and independence can be achieved by designing a series of integrated information systems that share a common core. While each IIS is tailored to a specific program's needs, it contains the basic information structures necessary to coordinate the various information systems. This design creates a seamless integration of services, facilitating provision of proper care and efficient resource management.

IIS provide storage capacity for numeric as well as for text data. Since much of the data needed by front line practitioners cannot be classified in advance and precoded into a limited number of numeric codes or fixed length data fields, IIS can store virtually unlimited free text data. This stored information can be later retrieved, incorporated into reports and used in qualitative data analysis. Furthermore, in certain contexts it may be useful to store pictorial information. For instance, an interdisciplinary team in the area of child abuse may need to store photos of bruises and burns allegedly related to physical abuse. These may help assessment and comparisons in the unfortunate event that another incidence occurs.

Data retrieval

The IIS addresses both the content and the form of information retrieval. Since these systems are designed to accommodate many partners with different skills and information needs, data retrieval capabilities are versatile. Current information systems are designed mainly to respond to data retrieval needs of administrators, managers and policy makers. These include interfaces that allow access to individual files, as well as to lists of clients, services received, payments or other resources allocated.

In addition to responding to these data retrieval needs, Integrated information systems provide clinicians with access to the information they need. The IIS provides clinicians with the capacity to browse through their client files as well as access to relevant information collected by other members of the agency. The IIS also provides 'tickler systems' which organize and retrieve important dates and activities and present them to practitioners as 'to do' or tracking lists (see Bhattacharyya, 1992 for an example). Sophisticated IIS interfaces can allow for natural language requests from the data base. Thus, clinicians can request retrieval of previous cases sharing characteristics with a current one. In addition, policy guidelines, service manuals, practice tips, abstracts of professional literature, and guides to services provided by other agencies, can all be accessed and retrieved from the IIS.

Given the emphasis on integration and on inclusion of as many partners as possible, issues of confidentiality and access are of prime importance. Much attention is given to the delicate balance between improved accessibility and retrieval of information, and protecting clients and workers from unacceptable intrusion of privacy. Involving as many partners as possible in the design process helps in fine tuning this vital balance.

Information processing

Computers provide a powerful means of processing and analyzing large amounts of information quickly. The challenge is to use this power to maximize the goals of the IIS. The most common way to process information in information systems is to aggregate information across cases. Thus, information systems count cases which satisfy certain criteria, crosstabulate them, and compute various statistics. For instance, Harrison and her associates (Harrison, Washington, Williams & Esterline, 1993) counted how many cases in a given period were under Protective Services investigation, and the distribution of the length of time needed to complete these investigations.

To better satisfy the information needs of front line clinicians, Integrated Information Systems emphasize aggregating and processing information pertaining to individual clients. This includes the analysis of many separate information items relating to a specific client in order to reach an overall assessment (see Nurius, 1990 for a review of automated assessment). Thus, for instance, when a behavior checklist such as the Adaptive Behavior Scale (Hile, 1990) is used to gather data on a client, the IIS analyzes the client responses, provides a client profile, and indicates to what extent this client deviates from known norms. Similarly, IIS may process all the information regarding a client unit in order to assess risk, to ascertain eligibility or to recommend the appropriate basket of services. Furthermore, the IIS facilitates client tracking by processing information regarding the client unit, collected at several points in time.

It is useful to distinguish between information processing that is programmed in advance, performed routinely and automatically as part of everyday use of the system, and processing which is more long term and requires reflection. The more automatic processing can be used for tasks such as assessing risk levels of clients, computing program compliance and quality assurance statistics, management and administrative house keeping statistics, etc..

Longer term, reflexive, and sequential analyses are also possible as data accumulate in the IIS data base. These data allow more in-depth analyses, enabling researchers and agency staff to explore issues involved in the process and outcomes of interventions. Sophisticated statistical analyses address issues such as clients' characteristics, services provided, performance and outcome assessments, client and service profile analysis, program retention and its predictors, and many more relevant analyses (Caputo, 1986). On the basis of these analyses decision aids can be designed and incorporated into the IIS.

Sicoly (1990) describes the development of a decision aid based on a statistical model predicting important service events. This statistical model can then become part of the IIS and be used to predict this event in the future. Argles (1983) used this approach to predict duration of child's stay in care, Stone and Stone (1983) performed multivariate analyses to statistically model the likelihood of placement breakdown or success, and Johnson and L'Esperance (1984) attempted to predict recurrence of abuse. These type of analyses can be performed easily within an IIS environment as the Integrated Information System routinely collects the data needed for statistical modeling of relevant critical events.

Reporting

Reporting capabilities are a crucial element of the IIS. As information is gathered, stored, retrieved and analyzed, it should be communicated and reported in a timely and accurate manner. Integrated Information Systems provide a wide array of reporting mechanisms in order to address the needs of all partners. A series of preprogrammed, 'canned reports', are readily available for routine use by administrators, managers, supervisors and direct line workers. A user friendly report generator provides the ability to design 'ad hoc' reports, and to allow users to tailor existing reports to suit their individual needs.

Further, to increase connectivity among various components of the agency, programs and services, and between the information systems of agencies and county- and State-level systems, reports can also be designed in the form of data files. These files can be transferred and shared by many relevant and appropriate users.

Traditionally, reports reflect the emphasis on the aggregation of data across many cases. Thus, most reports consist of lists, and of numbers describing classes of clients and of services. For instance, a report generated by Texas Department of Protective & Regulatory Services (Harrison et. al., 1993) describes for each stage of service what is the duration of that stage, and how this duration differs across programs and regions.

The IIS emphasis on the information needs of clinicians and on client-level processing, requires additional modes of reporting. To facilitate reporting on the client level, and to ease the heavy burden of reporting placed upon the individual clinician, a 'client report' is generated. This is a text report that resembles current written reports and can replace the hand written or typed report. This type of report takes all the relevant information from the client's file and implants it in sentences and paragraphs that are a hybrid of computer generated segments and free text entered by the worker at the data collection phase.

Various client reports are designed to meet different reporting requirements. For example, using the same data file of a client in a drug treatment program, different client reports can be generated for the court, the health insurance company, the clinical supervisor, and for the administration of the clinic. Thus, whereas data are entered only once, the IIS stores the information, retrieves it and uses it for as many different reports as necessary.

IIS Impact on Practice, Management and Policy Making

Implementing an IIS in an agency may have major impact on almost every aspect of the agency's functioning and on the relationship of the agency to other related organizations. A complete review of the impact of an IIS is beyond the scope of this paper (for such a review see Oyserman & Benbenishty, 1993). The following sections will highlight areas in which IIS may have a major impact.

IIS supports a quality process of service delivery

As the system structures data gathering, processing, communicating and reporting, it assures that all professional, legal and administrative directives are being followed. The expertise of the most knowledgeable people in the agency and in the professional literature is embedded in the system and guides practitioners, some of them novice and inexperienced.

IIS improves decision making

IIS provides support for decision making on all levels in several ways. The system ensures that all data needed for decisions have been collected properly and communicated to the appropriate decision maker on a timely basis. Further, the IIS can provide an array of decision aids ranging from help screens, access to relevant literature reviews (Shoech, 1993), risk assessment scales, expert system modules (Schuerman, 1988; Mullen 90), predictive statistical models (Sicoly, 1992), and other aids relevant to a specific domain.

IIS saves time and cuts cost

Information systems eliminate redundancies in data collection and reporting. Information items are entered only once and then copied and moved as needed. The time consuming process of report preparation is streamlined and shortened. The need for support staff to type various reports, check for errors and retrieve information from files is reduced significantly.

IIS improves quality of data

The information system provides means to ensure the quality and correctness of data at the point of entry. By providing lists, checklists and edit checks, the probability of omissions, contradictions, and typing errors is greatly reduced. Furthermore, because practitioners use the data daily and depend on these data for their work, they pay close attention to the completeness and accuracy of their documentation.

IIS strengthen reporting and data transfer

Data entered into the system are immediately available to all partners in the organization, cutting the time and effort involved in keeping each of the organization's departments and programs updated. A virtually unlimited number of reports designed to suit the agency needs combined with a flexible and user-friendly report generator, greatly enhance reporting capabilities. The system's ability to transfer data to other information systems is extensive. Data can be transferred electronically using various data formats to fit the characteristics of these related information systems.

IIS enriches program monitoring and research

The quality, extensiveness and immediate availability of data stored in the system make program monitoring and evaluation, quality assurance and research integral parts of practice and of policy making. In addition, the information system can serve as a platform for data collection efforts needed for research and other purposes such as program development or funding acquisition. For instance, a questionnaire may be added for a limited time to assess the need for a new service.

Epilogue

The conceptual framework outlined above and the methodology described here were the basis for a number of efforts to design effective methods to utilize information for practice. During the years we have designed systems to support family therapy, child residential care, and foster care (Benbenishty, 1991; Benbenishty & Ben-Zaken, 1991; Benbenishty & Oyserman, 1991). Presently we are implementing an Integrated Information System for Foster Care in Michigan (Benbenishty & Oyserman, 1993; Oyserman & Benbenishty, 1993). This system is much more extensive and sophisticated than our previous efforts. Initial responses are very encouraging. The process of development and implementation of the IIS has brought to the fore accountability and quality care issues. In the near future the impact of the IIS on accountability and development of empirical practice should be monitored and studied carefully.

Error Rates and Quality Control

Moderated by Ellen Konrad
Arizona Department of Economic Security

Reform of Federal Quality Control Systems: Reducing Erroneous Denials and Terminations - Gregory B. Mills, Ph.D., Abt Associates, Inc.

Food Stamp Caseloads and Error Rates: A Statistical Connection? - Kip K. Houge, U.S. Department of Agriculture

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Reform of Federal Quality Control Systems: Reducing Erroneous Denials and Terminations

Gregory B. Mills, Ph.D., Abt Associates, Inc.

The theme of this conference is self sufficiency. You may wonder what link exists between self sufficiency and quality control--in particular, between self sufficiency and quality control for denials and terminations of benefits ("negative case actions"). If entitlement programs are to promote self sufficiency for their intended recipients, these programs must be accessible to those who meet the conditions of eligibility. Those who seek assistance should be served, if they are indeed eligible. Once on the program, those who remain eligible and wish to continue to receive benefits should remain recipients. To the extent that benefits are denied or terminated to those entitled to receive them, these programs clearly stand less chance of meeting economic needs--less chance of promoting self sufficiency.

Most of you at this conference already have some familiarity with the basic features of the three programs--food stamps, Medicaid, and Aid to Families with Dependent Children (AFDC)--whose quality control (QC) systems I address here. Most of you also have some acquaintance with federal QC regulations for active cases--regulations that require each State to sample from its active caseload and to review the correctness of the eligibility and benefit determination. Active case reviews include examination of the case record and a field investigation involving an in-person client interview and verification of client circumstances through employers, local banks, landlords, or other collateral contacts.

For a subsample of these cases, federal regional staff then conduct a re-review to validate the original State finding. The State and federal findings then yield an official error rate for each State. States whose error rate exceeds a national standard become subject to a loss of federal funds.

In the Food Stamp Program, fiscal sanctions (or "liabilities") to States are based on a combined payment error rate that includes overpayments and underpayments. A State becomes subject to a fiscal liability if its combined payment error rate exceeds 10.31 percent of total issuances. For the most recent sampling period, Fiscal Year 1992, 15 States face liabilities. States with low error rates may qualify for an incentive payment (or "enhanced funding") by achieving a combined payment error rate of less than 6 percent and a negative case error rate below the prior year's national average. For Fiscal Year 1992, 4 States (and the Virgin Islands) qualified for enhanced funding.

In AFDC a State is subject to sanction (beginning in Fiscal Year 1991) if its overpayment error rate exceeds the national average (5.98 percent in 1990) or 4 percent, whichever is higher. The amount of sanction is adjusted downward if the State's underpayment error rate falls below the national average (0.79 percent in 1990). Based on State performance in 1990 (one year before the first effective year of the current provisions), 13 states would have faced sanction. The disallowance formula takes no account of negative case action errors.

In Medicaid, the tolerance level for overpayment error is 3 percent. A State is subject to sanction only if the lower bound of the confidence interval for its estimated error rate exceeds 3 percent. This is unlike food stamps or AFDC, where the point estimate of the error rate--not the lower bound--is the basis for sanction. For the most recent measurement period, Fiscal Year 1991, no States faced sanction. The negative case error rate has no bearing on the sanction; fewer than half of all States even conduct negative case action reviews in Medicaid.

I focus here on the quality control systems in these three programs for negative case actions--cases whose benefits have been denied or terminated. This is my first opportunity to draw together the findings from studies that we have conducted at Abt Associates over the past five years, first for the Food and Nutrition Service, then for the Health Care Financing Administration, and finally for the Administration for Children and Families.[1] All three federal program agencies asked us to study the following question: is it feasible to make the negative case action QC system more comparable to the system for active cases, in terms of both the measurement of error and the financial consequences to States of their errors?

Since the inception of federal QC systems in the 1970s, first in the AFDC program and then later in the others, negative case actions have received less attention than active cases, for several reasons:

> First, the primary federal policy concern historically has been to control the growth of caseloads and expenditures through reduction in overpayment error among active cases. The presumed source of errors was client misreporting. With little expectation that clients or caseworkers would act to deny or terminate benefits incorrectly, there was little perceived need to monitor negative case actions.
>
> Second, the program rules require agencies to provide advance notice to the client of a denial or termination and allowing clients the opportunity to request a fair hearing and to appeal. These rules were regarded as sufficient to protect clients from mistaken agency actions.
>
> Third, there was the recognition that a QC field investigation of a negative case action requires a level of client cooperation that may be difficult (if not impossible) to obtain from a denied or terminated client. For such a client, one can not threaten a loss of payment as a consequence for failure to cooperate with the QC review.
>
> Fourth, there was no clear statutory authority to sanction negative case action errors. One could not disallow funds for benefit payments not made.
>
> Fifth, and finally, there was a quandary over the appropriate definition of a dollar error rate that might serve as a negative case action performance measure.

During the mid-1980s, a number of developments caused renewed interest in negative case actions. Concerns arose that efforts to reduce overpayment error, in the face of ever-lower error standards and ever-tighter state budgets, had encouraged a mentality among State and local eligibility staff best described by the phrase "deny when in doubt." The imbalance in treatment of negative case action errors versus errors among active cases was addressed in a number of studies: reports by the General Accounting Office,[2] studies conducted by the National Academy of Sciences,[3] subsequent reports to the Congress from the Departments of Agriculture and Health and Human Services.[4] The desire to consider reforms in QC policy led the federal agencies to undertake the studies that I discuss here.

I address five questions, as indicated in Exhibit 1.

1. **Does the current negative case error rate tell us what we want to know about the accuracy of denials and terminations?**

Our research concluded that the answer is no, if one's aim is to obtain a measure of negative case action error that is comparable in definition and interpretation to the rates of overpayment and underpayment estimated for active cases.

Let's look first at the most recent national error rates in all three programs, as shown in Exhibit 2. The national overpayment error rate, which expresses payments to ineligible cases and overpayments to eligible cases as a percentage of total payments to active cases, is estimated at 7 to 8 percent in food stamps, 2 percent in Medicaid, and 6 percent in AFDC. The national underpayment error rate is 2 to 3 percent in food stamps and below 1 percent in AFDC, with no corresponding Medicaid estimate.

The currently estimated negative case error rate, which indicates the percentage of denials and terminations that are incorrect, is 6 to 7 percent in food stamps and 4 to 5 percent in AFDC. (Again, no corresponding national estimate exists for Medicaid.) These estimates indicate the percentage of actions for which neither the case record nor limited field investigation supports the caseworker's cited reason, nor does the case record support any other secondary reason. Under the current review procedure, an action is also considered incorrect if the agency has failed to comply with a procedural requirement, such as the need to take timely action on an application (within 30 days, for food stamps) or to provide timely notice to the client of the agency's decision to deny or terminate benefits. In AFDC, more than one-half of the incorrect actions have errors solely with respect to advance notice and hearing requirements, not with basic eligibility requirements.

The current review process is more a test of whether the caseworker was careful to document a decision and to follow appropriate agency rules than a test of whether the decision was substantively correct. The process does not focus on the issue of whether the case was actually eligible--i.e., whether any benefit loss thus occurred.

If one's interest is benefit loss, the current review procedure can yield misleading findings--on the one hand, a reviewer may find an action incorrect when there is no benefit loss. For example, there may be a secondary reason to deny or terminate, but this secondary reason is not apparent from the case record and the reviewer is not required to pursue other reasons through field investigation. This is a situation where the case is found in error, but there is actually no benefit loss.

Conversely, a reviewer may find an action correct when there is benefit loss. For example, the case record may simply not reflect the true circumstances of the case. The casefile documentation that supports the caseworker's reason may be factually wrong, but it is accepted by the QC reviewer because there is no need to seek further verification, as one would in an active case.

Our research also found that the Medicaid negative case action QC system does not include in its sampling universe some cases that have the potential for benefit loss. One category consists of spenddown cases--cases not immediately eligible, because of excess income, but that might become eligible if their medical expenses exceed a specified spenddown liability amount. A second category consists of AFDC denials or terminations where the case then does not go on to receive Medicaid on a "medical assistance only" (MAO) basis. Such AFDC/MA actions are subject to review as AFDC negative cases, but their potential benefit loss in Medicaid is not subject to review.

2. **What alternative measures of negative case action error might serve as a counterpart to the overpayment and underpayment error rates for active cases?**

Our research suggests that the system focus on two measures as alternatives to the current negative case error rate: a modified negative case error rate and a nonpayment error rate. Refer to Exhibit 3. The modified negative case error rate, as with the current measure, is a ratio of negative cases in error to total negative cases. However, the modified version regards a case as in error only if there is a benefit loss based on verified case circumstances--i.e., only if a field investigation by the QC reviewer finds no evidence that the client fails to meet a basic ("circumstantial") eligibility criterion or procedural requirement.

The nonpayment error rate is the dollar measure of negative case action error that most closely corresponds to the overpayment and underpayment error rates for active cases. Its numerator is the amount of total benefit losses to negative cases. Its denominator is the amount of total payments to active cases--the same denominator as the overpayment and underpayment error rates. This formulation thus has the advantage of allowing one to construct a composite error rate by summing the overpayment, underpayment, and nonpayment error rates.

As shown in Exhibit 3, one can decompose the nonpayment error rate into three factors:

- the modified negative case error rate;

- the ratio of the average benefit loss per negative error case to the average payment per active case; and
- the ratio of negative cases to active cases.

The middle term expresses the dollar magnitude of benefit losses (averaged among error cases only) in relation to benefit payments (averaged across active cases). Estimating the numerator of this second term for programs such as AFDC or food stamps is a straightforward exercise. Having identified a case that should not have been denied or terminated, a QC reviewer can determine the correct payment (i.e., the benefit loss) by performing a budget computation.

Medicaid, however, poses a more difficult error measurement task. In principle, the amount of Medicaid benefit loss should represent the amount of medical claims that *would have been paid* to the case, had the agency correctly determined eligibility. However, one should not assume that this counterfactual amount is accurately indicated by the case's observed utilization of health care while off the program. (Medicaid eligibility increases a person's access to health care, reduces the cost to the recipient, and may influence a provider's decision about services.) One must therefore impute the amount of Medicaid benefit loss. Our research examined a series of alternative imputation methods. The recommended one assumes that the average benefit loss per negative error case equals the average monthly paid claim to an active case.

3. How feasible are the necessary changes to QC sampling and review procedures?

To address this question, we conducted pilot tests in both food stamps and Medicaid. As shown in Exhibit 4, six States participated in food stamp pilot tests (all conducted by Abt Associates), and five States participated in Medicaid pilot tests (two conducted by Abt Associates and three conducted by Sociometrics, Inc.). The research undertaken in AFDC was a more limited effort in three States (conducted by Abt Associates), involving supplementary review of previously identified error cases, rather than an operational pilot test of a modified system. In the food stamp and Medicaid pilot tests a total of 2,627 cases were first reviewed under current procedures and then reviewed under modified procedures, with error findings and work measurement information recorded at the end of each stage.

From the pilot tests in food stamps and Medicaid, the modified sampling and review procedures appear operationally feasible; States have the necessary sampling data, and reviewers have the necessary knowledge and skills. However, these pilot tests identified several issues of legitimate concern, as discussed below: increased QC staff time to complete a negative case review and a higher proportion of incomplete reviews, due especially to client noncooperation.

The modified QC system would involve higher administrative cost because of the increased staff effort required to complete reviews. As shown in Exhibit 5, for both food stamps and Medicaid the proportional increase in staff time per completed review differed substantially by type of action (denial versus termination) and by current QC finding (correct versus error). The overall proportional increase in each program was 34 percent, reflecting the particular distribution of cases in the pilot sites. To the extent that QC reviews are highly labor-intensive, this implies an increase of about one-third in the costs of negative QC activity, even without increased sample sizes. The cost impact would be even larger to the extent that one may need to increase sample sizes in order to provide adequate statistical precision.

There is also legitimate concern over whether reviewers could obtain the necessary degree of client cooperation in conducting the additional field investigation required for some cases. For each pilot site, we computed a noncompletion rate that indicates the percentage of incomplete reviews among cases subject to review. As shown in Exhibit 6, the noncompletion rate was 13 percent in the food stamp pilot test and 2 percent in the Medicaid pilot test. (Client failure or refusal to cooperate was the reason for noncompletion in more than one-half of the incomplete cases. Inability to locate the household or the case record was also a significant reason.) A noncompletion rate as high as the 13 percent food stamp finding, which compares to a nationwide noncompletion rate for active food stamp cases of 3 percent, might appreciably bias any estimated error rate. However, the degree of noncompletion experienced in these pilot sites may reflect the newness of the modified review procedures to both QC reviewers and clients. With further experience, reviewers might have greater success in obtaining cooperation from denied or terminated clients, in those negative case reviews where client contact is necessary.

4. How do the alternative estimates of negative case action error compare with current estimates?

In answering this question, we draw once again on the findings from the pilot tests in food stamps and Medicaid, as shown in Exhibit 7. The first column of the exhibit shows the current negative case error rate, reflecting the current sample definition and review procedure. The second column shows the negative case error rate that results from applying the modified review procedure to currently sampled cases. (Under the multi-stage review method implemented in the pilot tests, the rates shown in these two columns for each site are based on the same sample of cases.) The third column then shows, for Medicaid, the negative case error rate that results from applying the modified review procedure to an expanded sample that includes the previously-mentioned spenddown cases and AFDC/MA cases in addition to those currently in the sampling universe.

For food stamps, the modified review procedure resulted in a lower negative case error rate in 5 of the 6 States. This reflects the fact that many errors found under the current system pertain to the 30-day processing standard for applications. Such cases are not considered in error under the modified review procedure. For Medicaid, the modified procedure resulted in a higher negative case error rate in 3 of the 5 States. Under an expanded sampling definition, the error rate was even higher in 4 of the 5 States.

The estimated nonpayment error rates are typically less than 0.5 percent when one accounts for the benefit loss that occurs in the first effective month of the denial or termination, as shown in the first column of Exhibit 8. To explain why these error rates are so small, in comparison to the typical dollar error rates for overpayment (or underpayment) among active cases, it is instructive to refer back to Exhibit 3, which expresses the nonpayment error rate as a product of three factors. The first factor, the modified negative case error rate, was typically in the range of 0.05 (or 5 percent) in the food stamp and Medicaid pilot tests (as indicated in Exhibit 7). The second factor, the ratio of the average benefit loss per negative error case to the average payment per active case, was typically close to 1.00 (or 100 percent) in all three programs studied. The third factor, the ratio of total negative cases to total active cases, was typically in the range of 0.10 (or 10 percent) in each program. The product of these illustrative values (0.05, 1.00, and 0.10) is thus 0.005 (or 0.5 percent). The last factor, which scales the nonpayment error rate into the same measurement terms as the overpayment or underpayment error rate, thus has the effect of substantially lowering the value of the nonpayment error rate.

One might regard the nonpayment error rate estimates mentioned thus far as understating the true extent of benefit loss, by arbitrarily limiting the error accounting period to one month. For an incorrectly denied or terminated case, benefit losses may extend in principle for many months, as long as the case remains continuously eligible for assistance but never reapplies. Under a one-month error accounting period, the nonpayment error rate does not reflect the possible multi-month duration of errors. Among active cases, in contrast, payment errors of long duration ultimately raise the estimated error rate, as cases remain subject to sampling in each month of benefit receipt (i.e., in each month of potential payment error). Among negative cases, however, each action is subject to sampling only once.

Given this concern over possible understatement of benefit losses, we collected data in the food stamp pilot test that allowed us to compute nonpayment error rates based on a three-month error accounting period. Even this approach does not fully account for benefit losses; however, it does highlight the limitations inherent in a one-month framework. As shown in the second column of Exhibit 8, the three-month nonpayment error rate is typically more than twice as large as its one-month counterpart. Although the three-month rates achieve a more complete accounting of benefit losses, such estimates are more difficult and costly to obtain, as the reviewer must record and verify additional case information. For this reason, our primary research focus was the one-month nonpayment error rate.

5. How might one apply the alternative measures of negative case action error?

For any of the three programs, one could apply the alternative error measures in a variety of ways. One possible strategy is to estimate a modified negative case error rate for each State and publish the results annually so that States become publicly accountable for the accuracy of their denials and terminations. Another approach is to use these error rates to focus State and federal resources more effectively on corrective action--for example, requiring State corrective action plans and federal regional monitoring where error rates exceed the national average.

A more ambitious policy strategy is to reform the system of fiscal sanctions (and incentive payments) to States in order to balance the financial consequences of all errors. For each of the three programs, we considered a range of options for broadening the scope of error rate standards to include the nonpayment error rate and thus attach some financial consequence to negative case action errors. Because the nonpayment error rate is typically so low, the pattern of sanctions (or incentive payments) that would result under any of these options differs very little from the pattern under current policy.

For this reason, and because of the uncertainties surrounding the issues of administrative cost and client noncooperation, our recommendation to each agency was to proceed incrementally toward reform. In food stamps, because of the higher rate of client noncooperation found in the pilot test, we were very cautious about the merits of a modified system and did not recommend its adoption. In AFDC and Medicaid, we recommended a modified review procedure (and in Medicaid, an expanded sampling universe) to focus the system directly on the issue of benefit loss.

This brings me finally to the reports to Congress that each of the federal program agencies has now submitted.[5] The July 1990 report from the Food and Nutrition Service called for strengthened monitoring of State compliance with existing QC provisions and improved reporting of errors (to distinguish, for instance, purely procedural errors from those related to basic eligibility requirements). The Health Care Financing Administration (in November 1992) and the Administration for Children and Families (in August 1993) called for a modified review procedure (and, in Medicaid, an expanded sample definition). In sum, the federal agencies have acknowledged the limitations of their current quality control systems and have proposed some steps, as recommended in the research summarized here, toward achieving greater comparability in the measurement of errors between the active cases and negative case actions.

Exhibit 1

RESEARCH QUESTIONS

1. Does the current negative case error rate tell us what we want to know about the accuracy of denials and terminations?

2. What alternative measures of negative case action error might serve as a counterpart to the overpayment and underpayment error rates for active cases?

3. How feasible are the necessary changes to QC sampling and review procedures?

4. How do the alternative estimates of negative case action error compare with current estimates?

5. How might one apply the alternative measures of negative case action error?

Exhibit 2

RECENT NATIONAL ERROR RATES IN FOOD STAMPS, MEDICAID, AND AFDC

Program and year	Overpayment error rate	Underpayment error rate	Negative case error rate
	Payments in error		Cases in error
	as a percentage of total payments	as a percentage of total cases	
Food stamps			
1990	7.34%	2.47%	6.67%
1991	6.96	2.35	5.80
1992	8.19	2.50	na
Medicaid			
1990	1.9	na	na
1991	1.9	na	na
AFDC			
1990	5.98	0.79	4.4

Notes: All error rates are weighted national averages. Overpayment error rate includes payments to ineligible cases and overpayments to eligible cases. For food stamps and AFDC, the overpayment and underpayment error rates are regressed rates. For Medicaid, the overpayment error rates are substitution rates. The "na" indicates not available.

Exhibit 3

ALTERNATIVE MEASURES OF NEGATIVE CASE ACTION ERROR

Current negative case error rate

$$= \text{negative cases in error} \div \text{total negative cases}$$

Modified negative case error rate

$$= \text{negative cases in error}^{*} \div \text{total negative cases}$$

Nonpayment error rate

$$= \text{total benefit losses to negative cases} \div \text{total payments to active cases}$$

$$= \text{modified negative case error rate} \times \frac{\text{average benefit loss per negative error case}^{*}}{\text{average payment per active case}} \times \frac{\text{total negative cases}}{\text{total active cases}}$$

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*Negative cases with benefit loss

Exhibit 4

PILOT TEST SITES AND SAMPLE SIZES

Program and State	Pilot site	Number of negative cases reviewed under modified procedures
Food stamps[a]		
California	San Diego County	236
Illinois	Cook County	243
Maryland	Baltimore City	185
Michigan	Lapeer, Livingston, Macomb, and Oakland Counties	252
Texas	San Antonio Region	210
Utah	Salt Lake, Davis, Morgan, and Weber Counties	239
Total		1,365
Medicaid[b]		
California	Los Angeles County	301
Montana	Statewide	256
Texas	Houston Region	228
West Virginia	Statewide	203
Wisconsin	Dane and Milwaukee Counties	274
Total		1,262
AFDC[c]		
Florida	Statewide	26
Michigan	Statewide	41
Texas	Statewide	22
Total		89

Notes: [a] Conducted in 1989 by Abt Associates.

[b] Conducted in 1990 by Abt Associates in Texas and Wisconsin; conducted in 1991 by Sociometrics in California, Montana, and West Virginia.

[c] Conducted in 1992 by Abt Associates; error cases only, reviewed to determine the dollar amount of benefit loss (if any) experienced by each case.

Exhibit 5

EFFECT OF MODIFIED REVIEW PROCEDURE ON STAFF TIME PER COMPLETED REVIEW

Case type and current QC finding	Minutes per completed review		
	Current procedure	Modified procedure	Percentage increase
Food stamps			
Denial			
Correct	67	92	37%
Error	109	243	123
Termination			
Correct	65	77	18
Error	83	274	230
Total (weighted)			34
Medicaid			
Denial			
Correct	26	31	19
Error	30	41	37
Termination			
Correct	27	37	37
Error	39	56	44
Total (weighted)			34

Exhibit 6

EXTENT OF INCOMPLETE REVIEWS UNDER THE MODIFIED REVIEW PROCEDURE

	Cases subject to review under modified procedure	Cases with incomplete reviews	Noncompletion rate
Food stamps			
California	292	56	19%
Illinois	254	11	4
Maryland	276	91	33
Michigan	276	24	9
Texas	233	23	10
Utah	243	4	2
Total	1,574	209	13
Medicaid			
California	249	9	4
Montana	185	6	3
Texas	228	0	0
West Virginia	146	4	3
Wisconsin	277	3	1
Total	1,085	22	2

Exhibit 7

NEGATIVE CASE ERROR RATES UNDER DIFFERING SAMPLE DEFINITIONS AND REVIEW PROCEDURES

	Under current sample definition:		Under expanded sample definition:
Program and site	Current review procedure	Modified review procedure	Modified review procedure
	Negative cases in error as a percentage of total negative cases		
Food stamps[a]			
California	6.36%	4.24%	—
Illinois	4.12	4.53	—
Maryland	14.59	13.51	—
Michigan	8.33	1.59	—
Texas	9.52	2.38	—
Utah	1.26	0.84	—
Medicaid[b]			
California	5.38	8.40	8.44%
Montana	0.00	3.28	6.64
Texas	2.04	2.04	16.00
West Virginia	4.17	4.17	9.72
Wisconsin	4.40	6.59	2.33

Notes: [a] For food stamps, the "current sample definition" applies the existing QC rules that identify cases subject to review.

[b] For Medicaid, the "current sample definition" includes denials and terminations of medical assistance only (MAO) for reasons other than excess income. The "expanded sample definition" includes spenddown cases (cases not immediately eligible because of excess income, to whom the agency has assigned a spenddown liability amount) and AFDC/MA cases (AFDC denials or terminations where the case does not receive Medicaid on an MAO basis).

Exhibit 8

NONPAYMENT ERROR RATES

Program and site	Duration of error accounting period 1 month	3 months
	Total benefit losses to negative cases as a percentage of total payments to active cases	
Food stamps		
California	0.60%	1.29%
Illinois	0.16	0.33
Maryland	0.17	0.44
Michigan	0.11	0.26
Texas	0.05	0.08
Utah	0.04	0.09
Medicaid		
California	0.68	na
Montana	0.49	na
Texas	1.84	na
West Virginia	0.52	na
Wisconsin	0.09	na

Notes: For food stamps, the amount of benefit loss was computed for each error case for both a one-month and three-month accounting period. For Medicaid, the amount of benefit loss was assumed to equal the average monthly paid claim to an active case. The "na" indicates not available.

Notes

1. For a more detailed description of the research findings, refer to:

   Gregory B. Mills and David C. Hoaglin, Redesign of the Negative Action Quality Control System in the Food Stamp Program: Final Report, Abt Associates Inc., Cambridge, Mass., June 1990;

   Gregory B. Mills and David C. Hoaglin, Medicaid Negative Action Quality Control Study: Final Report, Abt Associates Inc., Cambridge, Mass., November 1990;

   Gregory B. Mills and David C. Hoaglin, Medicaid Negative Action Quality Control Penalty Study: Conceptual Development and Feasibility Report, Abt Associates Inc., Cambridge, Mass., September 1991;

   Medicaid Negative Action Quality Control Penalty Study: Final Report, Sociometrics, Inc., Hyattsville, Maryland, November 1991; and

   Gregory B. Mills and David C. Hoaglin, AFDC Negative Case Action Quality Control Study: Final Report, Abt Associates Inc., Cambridge, Mass., September 1992.

2. See U.S. General Accounting Office, Food Stamp Program: Restoration of Improperly Denied or Terminated Benefits, GAO/RCED-87-51, October 1986; and Food Stamp Program: Evaluation of Improper Denial or Termination Error Rates, GAO/RCED-88-12, October 1987.

3. See U.S. Department of Agriculture, Food and Nutrition Service, The Food Stamp Quality Control System: A Report to the Congress, May 1987; and U.S. Department of Health and Human Services, Quality Control in AFDC and Medicaid: A Report to the Congress, March 1988.

4. See Dennis Affholter and Fredrica D. Kramer (eds.), Rethinking Quality Control: A New System for the Food Stamp Program, Washington, DC: National Academy Press, 1987; and Fredrica D. Kramer (ed.), From Quality Control to Quality Improvement in AFDC and Medicaid, Washington, DC: National Academy Press, 1988.

5. See U.S. Department of Agriculture, Food and Nutrition Service, Reforming the Negative Action Quality Control System: A Report to the Congress, July 1990; and U.S Department of Health and Human Services, Report to Congress: Medicaid Eligibility Quality Control, Negative Case Action Program Study, November 1992, and Report to Congress: Aid to Families with Dependent Children, Negative Case Action Quality Control Study, August 1993.

Food Stamp Caseloads and Error Rates: A Statistical Connection?

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A belief which has become popular over the past several years is that the rapidly increasing caseloads are the major cause of rising error rates. This connection, this relationship between Food Stamp caseload and error rates, has become almost an accepted fact of life in many circles. It seems to be a reasonable assumption --- almost a logical tautology: as the caseloads change, so will the error rates. This is supposedly due to the eligibility worker being forced to process more cases in the same amount of time, thus being more prone to making mistakes. It became such a "given" fact, that even some skeptics began to assume it to be true. The speculation screamed for a statistical, analytical examination. So being one of those skeptics on the brink of acceptance, I embarked on this study. Not to show what does affect the error rate, but to determine whether the caseload is a contributing factor with respect to the error rate changes.

While statistics cannot demonstrate a cause-and-effect relationship, or lack thereof, it can determine a numeric association or correlation. Just because two variables follow the same trend or pattern, does not necessarily mean that one **causes** the other to move that way or is affected, directly or indirectly, by the other. All statistics can do is look for similarities or mathematical dependencies.

The investigation began with looking at the "big picture", i.e., the trends of the National average Food Stamp caseload and error rates from 1983 to 1992 (Table I and Graph 1), in order to get some initial perspective. From 1983 through 1988, there was a gradual decline in the caseload. After bottoming out in 1988, the caseload took an upturn, increasing at an increasing rate every year up to the 1991 fiscal year. From 1991 to 1992, the caseload still increased, but the rate of increase stabilized.

During that same 10-year span of time, the Combined Payment Error Rate (CPER) followed, somewhat, the same course. The exceptions being, (1) a temporary increase in 1984, (2) a minimum in 1989 (rather than the caseloads' nadir in 1988), and (3) a downturn in 1991. If we assume that (1) and (3) were abnormalities (even though there is no reason that we should make such an assumption), then we could generally say that these two variables follow the same pattern, just offset by a year. The trend in the error rates could be said to simply "lag" behind the caseload trend by a year.

But these may not be unexplainable abnormalities. The patterns may actually not be the same. There may be some other factor(s) camouflaging, or altering, the true relationship. For example, there maybe a few very large states which are dominating the national averages. For the purpose of this study, however, I wanted to look at the relationship on a more individualized level. Can a single, non-specific, state agency automatically say that its error rate went up (or down) because it experienced an increase (or decrease) in its caseload?

So the next step was to make comparisons of the data on a consolidated, state-level basis. I looked at how the average monthly caseloads and CPER's changed from year to year (refer to Table II for 1987 to 1992 data) to see if there was a correlation. In looking at the scatter diagram (Graph 2.A.) of the 265 data pairs, there is no discernable pattern; and there is certainly no obvious **linear** relationship. This latter statement is confirmed by a calculated correlation coefficient of r=.12107. While this is (just barely) significant at a 95% confidence level, it means that only 1.5 percent (r^2 = .01466) of the variation in CPER changes can be explained by the changes in state caseload.

A least-squares regression estimator was computed on this data of y = .2304x + .0725. As anticipated from Graph 2.A. and a regression coefficient that is only marginally significant, the regression line looks like a bullet going through a beehive (see Graph 2.B.) --- a pictorial representation of an ineffectual statistical estimator.

In an attempt to get a clue as to what modifications I could make in this segment of the analysis, the residuals (i.e., the difference between the error rate change estimated by the regression and the actual change itself) were examined. When plotted against either the dependent or independent variable, the scatter diagrams (Graph 2.C.) appear to be random. When the residuals are plotted against the caseload data, however, there is some slight indication that this regression estimator might be more accurate in states with larger populations. The range of residuals narrows as the caseload increases (Graph 2.D.).

To pursue this possibility, the data were stratified into five groups based upon the average monthly caseload. The correlation and associated data are tabulated below (and in Graphs 2.E):

Average Monthly Caseload	r	n	Test Statistic
> 225,000	.3146	49	2.2722 *
124 - 225,000	.2662	59	2.0848 *
60 - 124,000	.0428	57	0.3175
15 - 60,000	.0644	67	0.5201
< 15,000	.0083	33	0.0462
ALL	.1211	265	1.9779

* significant at the $\alpha = .05$ level

While this does show that the relationship between the change in the caseload and the change in the CPER is stronger for states with larger caseloads, even the highest correlation coefficient of .3146 for those VERY large states (e.g., California, Texas, New York, Illinois) is not something to get too excited about --- still only (r^2=) 9.9 percent of the variation in CPER change has been explained by the change in caseload.

I also looked at the basic assumption being tested in a more general sense: The error rate will change in the same direction as the change in the caseload. The table below summarizes the changes from 1987 through 1992.

		Change in CPER:		
		decrease (-)	increase (+)	
Change in Caseload:	-	40 (35.15)	28 (32.85)	68
	+	97 (101.85)	100 (95.15)	197
		137	128	265

(expect values are given parenthetically)

In only 140 out of the 265 instances (52.8%) did the general assumption hold. Using a chi-squared test, one cannot reject the hypothesis that these two variables, classified in this manner, are independent.

So to summarize this portion of the analysis, no evidence was found to support the concept that the change in Food Stamp caseload from one period to the next has a noteworthy, across-the-board connection to the change in error rate over that same period of time. The most one can say is that, in states with very large Food Stamp caseloads, the correlation between these two variable is statistically significant, but **very** weak.

A slight modification to the conjecture tested above is that the change in caseload from period #1 to period #2 has a connection with the change in error rate from period #2 to period #3. In other words, the change in CPER "lags" behind, by one year, the change in caseload. The assumption here is that it takes some number of months for the change in eligibility worker caseload to gradually affect their quality of work and thus impact on the number and amount of errors found by QC. And as was seen above in the discussion of National trends, the CPER's did start increasing a year after the caseloads turned upward.

This assumption was tested in the same manner as above. A correlation was calculated, a regression line generated, and the residuals of that estimator inspected. The outcome, however, was essentially unchanged. The correlation (using 212 data points this time) was only 0.0642 (statistically insignificant at the $\alpha = .05$ level), thus explaining less than one percent of the change in CPER vis-a-vis the change in caseload. An examination of the residuals again pointed towards a possible link between the effectiveness of the regression estimator ($y = .1257x_{-1} + 1.2640$) and the size of the caseload. As before, the data was stratified,....this time into four caseload groupings (see Table 3.E.). And again, the correlations for the higher caseload strata (i.e., greater than 150,000 per month) were larger, **but all were statistically insignificant.** Even in the strata with the highest correlation ($r = .3182$), only slightly more than 10 percent of the variation could be attributed to the change in caseload.

And again, as in the first analysis segment, a more general look was taken at the relationship. If the caseload goes up (regardless of the amount) does the CPER increase also, and vise-versa. The ratio (51.8%) of situations obeying this general assumption was approximately equivalent to the ratio in the prior analysis; and again the chi-squared test would not allow one to reject the null hypothesis that these variables are independent.

The caseload vs. error rate association could be taken another step further. The assumption is that the major cause of errors on the part of the eligibility workers is the magnitude of his/her workload: the more cases to handle, the higher the likelihood that an error(s) will occur. Extending that theory would mean that if an increase in the caseload is matched by a proportional increase in the resources invested in certifying those households (e.g., an increase in the number of workers), then the rate of errors should be unaffected. To explore this extension of the assumption analyzed above, certification costs per household was used as the explanatory/independent variable rather than just the caseload. These data for Fiscal Years 1987 through 1992 are presented in Table III.

The results of this line of attack, however, were very similar to those from the analysis using the average monthly caseload. The correlation ($r = -.074510$) was insignificant, even though negative coefficient at least indicates the assumed relationship (i.e., as the cost/per household is increased, the error was suppose to decline). An examination of the residuals again gave no clear indication as to any beneficial modifications which could be made to our analysis. The chi-square analysis of relative increases and decreases in the variables again did not show conclusively that independence could be rejected.

"Lagging" the change in cost per household behind the change in CPER improved the correlation only minimally (r was less significant, however, because the number of data points decreased), and the chi-squared test was even further from showing any statistical significance.

One last avenue that was pursued was using multiple regression with the change in caseload (x_1) and the change in certification costs per household (x_2) both as explanatory variables. Since the employment of lagged variables in previous analyses proved to be of little gain, such an effort was not made here. As expected, multiple regression was somewhat more successful in explaining the change in the error rate. This estimator ($y = .302x_1 - .048x_2 - 1.935$) produced a squared multiple correlation coefficient of .0413, thus accounting for 4.13 percent of the total variation. The hypothesis that $ß_1$ and $ß_2$ are both equal to zero was tested and marginally rejected at the $\alpha = .05$ level. While this is the best estimator tested in this study (see chart below), it hardly qualifies as noteworthy.

To summarize the five different means by which I attempted to link the changes in caseloads and CPER's, the table below gives some important statistics:

Independent Variable(s)	n	r	**	r^2	b_1	chi^2 *
Change in....						
Caseload	265	.12107	1.978	.01466	.23042	1.8588
Caseload(L)	212	.06420	0.932	.00412	.12569	0.4987
Cost/HH	153	-.07451	-0.918	.00555	-.10493	2.062
Cost/HH(L)	102	-.0841	-0.844	.00708	-.12237	0.016
Cost&Csld.	147	- - -	- - -	.04131 &-.04837	.30208	- - -

L = "Lagged" *critical value of chi^2 = 3.84

** critical values of r vary from 1.98 ($n=100$) to 1.96 ($n \geq 500$)

= =

The goal of this paper was to test the supposition that changes in the Food Stamp caseload affect the magnitude of errors committed by the eligibility workers. This is a hypothesis that has become so accepted that State Agencies can receive a "good cause" waiver from paying penalties for excessive Food Stamp error rates if their caseload growth was more than 15 percent. But from the analyses detailed above, such a relationship is at best weak and, depending on the form of the explanatory variable, usually non-existent. The most successful of the five estimators tested explained only slightly more than 4 percent of the variation in the CPER changes. Almost 96 percent of the influence on error rate changes is coming from other sources. To determine what these other sources are was not an objective of this paper. For those interested in some conjectures as to what these might be, please see the referenced Baker & Vosburgh (1977) article related to AFDC data.

Now some may still not believe the conclusion of this paper. Some want to ignore the attached scatter diagrams that show data pairs that look like a blind man's attempt at target practice, and instead look at the trends of these two variables in their particular state. And I'm not denying that in various individual states that the two may move in unison. But even if this was relevant, which it is not, several counter-examples from other States can be put up against every such situation. The point this paper is trying to make is that, **in general,** there is no significant correlation between the amount of change in the caseload (or the caseload adjusted for the financial resources employed to certify it) and the change in the error rate.

REFERENCES:

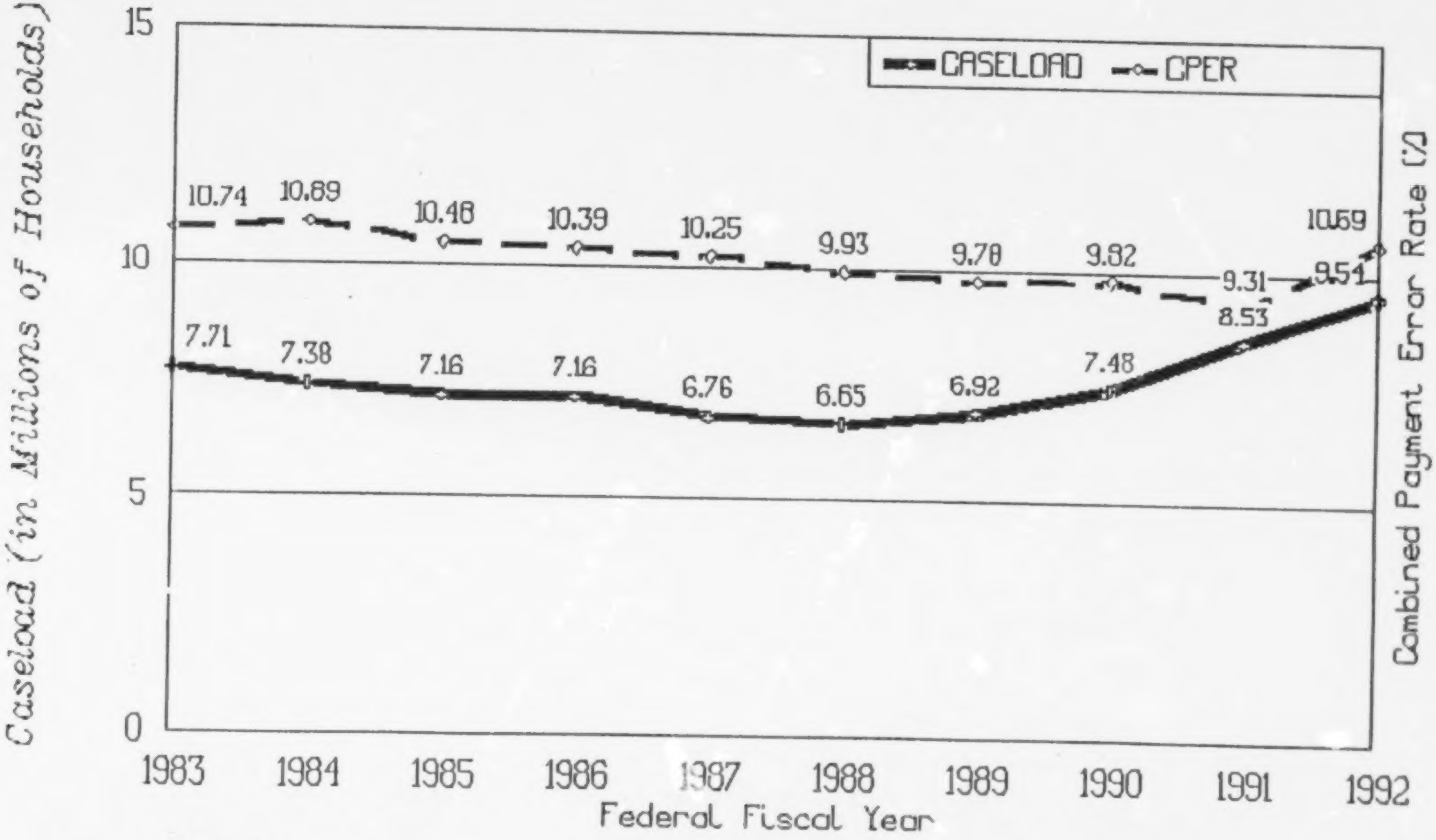
Timothy Baker and W. W. Vosburgh, "Workers, Cases, and Errors: The Effect of Work Load on Errors in Public Assistance Eligibility Determinations," *Administration in Social Work,* Summer 1977, pp. 161-170

Norman R. Draper and Harry Smith, *Applied Regression Analysis,* (John Wiley & Sons, Inc., 1966)

FEDERAL FISCAL YEAR	U.S AVERAGE MONTHLY FS CASELOAD (HOUSEHOLDS)	NATIONAL COMBINED PAYMENT ERROR RATE
1983	7,713,126	10.74
1984	7,380,259	10.89
1985	7,164,932	10.48
1986	7,155,196	10.39
1987	6,755,073	10.25
1988	6,648,980	9.93
1989	6,921,552	9.78
1990	7,476,843	9.82
1991	8,529,861	9.31
1992	9,536,900	10.69

TABLE I

U.S. AVERAGE MONTHLY CASELOAD
And ERROR RATE
1983 through 1992



Graph 1

TABLE II

STATE	COMBINED PAYMENT ERROR RATE OFFICIAL FY 87	OFFICIAL FY 88	OFFICIAL FY 89	OFFICIAL FY 90	OFFICIAL FY 1991	OFFICIAL FY 1992	X	AVERAGE MONTHLY CASELOAD CASELOAD FY 87	CASELOAD FY 88	CASELOAD FY 89	CASELOAD FY 90	CASELOAD FY 91	CASELOAD FY 1992
CONNECTICUT	8.78	7.68	9.42	10.08	8.65	8.12	X	41601	39171	41479	49988	67172	82177
MAINE	6.53	7.43	8.39	8.35	7.18	8.43	X	40629	36720	37011	41356	49976	57408
MASSACHUSETTS	11.55	11.3	9.44	13.06	6.92	7.40	X	132249	128846	137578	150072	170480	178901
NEW HAMPSHIRE	10.32	7.77	8.37	10.78	10.53	12.05	X	8819	8598	10075	13192	19440	24123
NEW YORK	12.73	12.89	15.24	13.88	10.86	11.20	X	688143	664500	671500	681720	775920	865184
RHODE ISLAND	8.12	9.08	10.02	5.5	7.47	4.45	X	25727	24329	24824	26747	33058	37103
VERMONT	8.2	9.03	11.04	7.96	8.86	6.39	X	15049	14414	14897	16863	19804	22715
DELAWARE	5.89	8.55	8.41	8.28	8.08	8.38	X	10713	10287	10770	12002	14754	18647
DIST. OF COL.	9.31	14.57	9.85	9.16	7.06	10.56	X	24553	24008	25173	26892	31077	38274
MARYLAND	9.38	8.63	10.07	10.64	9.00	8.99	X	99956	97680	101460	105209	124887	142449
NEW JERSEY	9.48	7.51	7.50	8.23	6.32	8.18	X	134668	124029	124154	136436	156712	181720
PENNSYLVANIA	9.98	8.68	6.44	6.83	6.24	8.13	X	370773	362212	362292	379237	418307	480666
VIRGINIA	8.04	7.45	8.45	6.96	9.49	8.91	X	126689	126735	132299	139114	167170	202826
VIRGIN ISLANDS	8.87	7.12	6.64	9.17	10.34	5.65	X	6716	4774	4379	3661	4304	4868
WEST VIRGINIA	9.68	10.38	11.47	11.27	11.72	10.64	X	89377	75753	89004	89686	96840	110020
ALABAMA	10.74	9.86	5.84	5.75	5.18	8.23	X	158250	152005	149702	156803	173767	201956
FLORIDA	10.32	9.38	11.09	9.66	10.89	19.68	X	226713	208297	264813	315403	416820	512705
GEORGIA	14.62	10.8	10.08	13.22	9.02	10.96	X	174185	171555	167265	193454	237478	284994
KENTUCKY	6.36	5.48	4.79	4.36	5.18	4.85	X	172833	163822	163534	168287	182393	196193
MISSISSIPPI	8.29	8.07	9.74	10.07	9.29	10.08	X	153093	153773	161182	168345	176122	180377
NORTH CAROLINA	12.09	9.14	8.53	7.14	8.16	8.89	X	157925	152468	150945	164168	199573	246139
SOUTH CAROLINA	14.32	13.68	9.13	8.06	9.64	9.00	X	97091	88154	81552	86875	105515	127743
TENNESSEE	11.24	12.12	8.78	8.28	8.51	13.12	X	181355	180621	175784	197046	229826	264732
ILLINOIS	11.06	10.6	10.42	10.9	9.85	9.97	X	356513	349676	382329	396853	458380	396691
INDIANA	11.96	11.47	9.90	11.38	12.83	13.58	X	105545	96809	97161	108593	128204	163199
MICHIGAN	8.45	8.33	7.58	8.89	7.36	9.05	X	316132	320083	359975	385771	360963	398869
MINNESOTA	7.99	8.65	10.50	9.67	8.58	10.48	X	87600	88667	92133	98753	109791	124000
OHIO	9.47	10.78	11.33	11.18	12.54	13.35	X	452454	444123	455649	448393	476437	459213
WISCONSIN	11.65	11.15	10.86	10.83	10.05	9.65	X	105264	96456	91067	89121	92770	114572
ARKANSAS	5.28	5.44	7.22	5.99	7.06	7.30	X	82939	81413	81213	84375	91318	99778
LOUISIANA	11.01	9.8	11.82	11.38	10.74	9.15	X	221141	226784	233783	239475	235121	250669
NEW MEXICO	13.61	9.68	8.82	8.89	7.56	8.55	X	50388	47408	47944	51704	63449	74825
OKLAHOMA	14.73	12.29	8.62	6.45	7.36	8.92	X	103378	104082	100203	103173	115962	133093
TEXAS	10.05	10.25	9.24	10.46	10.46	11.83	X	451794	476488	518792	623666	752565	877074
COLORADO	8.04	8.63	7.72	6.28	7.06	7.80	X	68429	72921	75261	78597	88107	103628
IOWA	9.3	10.64	10.64	11.82	8.50	10.74	X	74151	67994	66225	67371	70040	75419
KANSAS	6.01	6.21	8.47	7.99	7.39	6.89	X	44209	43368	46162	49732	54840	62569
MISSOURI	8.61	8.8	10.39	8.32	8.60	9.77	X	118738	124033	130363	161752	185125	208318
MONTANA	7.25	5.9	5.52	6.3	6.85	8.97	X	22156	18920	21007	20709	20118	23466
NEBRASKA	10.79	8.87	14.09	9.62	9.36	9.29	X	34137	32947	34514	37029	38493	41537
NORTH DAKOTA	4.43	5.41	5.78	5.86	5.56	5.89	X	14100	12792	12614	13930	14659	16942
SOUTH DAKOTA	3.32	4.45	4.97	4.85	4.00	4.52	X	16690	17710	17092	17173	17013	19824
UTAH	5.75	8.22	7.60	6.56	7.25	7.13	X	26979	28996	31923	33656	39064	42718
WYOMING	7.83	7.64	7.90	7.8	9.12	8.65	X	9294	9464	9256	9717	10797	11470
ALASKA	6.48	10.84	10.49	7.38	7.58	8.43	X	9316	9241	8416	8100	9796	12545
ARIZONA	9.39	9.85	10.58	10.93	11.23	13.35	X	60409	68445	68607	100317	126229	153811
CALIFORNIA	12.2	11.74	11.07	11.64	10.36	10.71	X	514614	524825	557496	657969	793267	833252
GUAM	8.48	4.76	4.93	5.8	9.89	8.99	X	3787	3591	3414	3348	3291	3558
HAWAII	4.41	5.34	5.06	4.06	3.19	3.85	X	31875	29988	29940	30770	32618	36131
IDAHO	8.25	10.41	7.85	8.44	9.51	7.18	X	18733	19807	18852	19303	21121	23300
NEVADA	3.81	2.69	4.82	6.49	7.79	6.87	X	15207	15689	17739	20538	26216	36716
OREGON	8.99	10.11	8.78	8.28	8.01	9.21	X	91698	84586	86693	88374	97724	109847
WASHINGTON	10.35	10.27	9.41	10.08	11.22	11.73	X	110296	118923	124057	129387	124988	167946

	*** CPER ***				X	X	FY 1992	FY 1992 CERT COSTS		FY 1991	FY 1991 CERT COSTS		FY 1990	FY 1990 CERT COSTS		FY 1989	FY 1989 CERT COSTS	
STATE	OFFICIAL FY 89	OFFICIAL FY 90	OFFICIAL FY 1991	OFFICIAL FY 1992	X	X	CASELOAD (x 1000)	$ Mill.	Per HH	CASELOAD (x 1000)	$ Mill.	Per HH	CASELOAD (x 1000)	$ Mill.	Per HH	CASELOAD (x 1000)	$ Mill.	Per HH
CONNECTICUT	9.42	10.08	8.65	8.12	X	X	82.177	5.883	5.965781	67.17	5.935	7.363158	49.99	3.421	5.702807	41.479	2.932	5.890531
MAINE	8.39	8.35	7.18	8.43	X	X	57.408	3.586	5.205430	50	3.371	5.618333	41.36	3.156	6.358801	37.011	2.898	6.525087
MASSACHUSETTS	9.44	13.06	6.92	7.38	X	X	178.901	9.252	4.309646	170.48	8.798	4.300602	150.07	8.557	4.751671	137.578	8.459	5.123760
NEW HAMPSHIRE	8.37	10.78	10.53	12.05	X	X	24.123	.846	2.922522	19.44	.944	4.046639	13.19	.612	3.866566	10.075	.649	5.368073
NEW YORK	15.24	13.88	10.86	11.20	X	X	865.184	75.674	7.288816	775.92	70.809	7.604843	681.72	78.096	9.546441	671.5	80.458	9.984860
RHODE ISLAND	10.02	5.50	7.47	4.40	X	X	37.103	1.737	3.901302	33.06	1.64	4.133898	26.75	1.253	3.903427	24.824	1.337	4.488264
VERMONT	11.04	7.96	8.86	6.39	X	X	22.715	1.049	3.848411	19.8	.972	4.111953	16.86	.959	4.740016	14.897	1.014	5.672283
DELAWARE	8.41	8.28	8.08	8.38	X	X	18.647	2.196	9.813911	14.75	2.084	11.77401	12	2.036	14.13889	10.77	1.848	14.29898
DIST. OF COL.	9.85	9.16	7.06	10.56	X	X	38.274	4.515	9.830433	31.08	3.561	9.547941	26.89	3.028	9.383910	25.173	3.179	10.52384
MARYLAND	10.07	10.64	9.00	8.99	X	X	142.449	8.698	5.088371	124.89	8.61	5.745056	105.21	11.927	9.446979	101.46	13.333	10.95095
NEW JERSEY	7.50	8.23	6.32	8.18	X	X	181.72	27.364	12.54861	156.71	28.686	15.25429	136.44	24.74	15.11043	124.154	21.882	14.68740
PENNSYLVANIA	6.44	6.83	6.29	8.13	X	X	480.666	54.352	9.423037	418.31	53.126	10.58346	379.24	48.886	10.74210	362.292	43.133	9.921325
VIRGINIA	8.45	6.96	9.49	8.91	X	X	202.826	28.111	11.54972	167.17	24.63	12.27792	139.11	19.392	11.61671	132.299	18.752	11.81163
VIRGIN ISLANDS	6.64	9.17	10.28	5.65	X	X	4.868	1.252	21.43248	4.3	1.172	22.71318	3.66	1.01	22.99636	4.379	.969	18.44028
WEST VIRGINIA	11.47	11.27	11.89	10.64	X	X	110.02	3.583	2.713901	96.84	3.566	3.068636	89.69	3.394	3.153454	89.004	3.006	2.814480
ALABAMA	5.84	5.75	5.18	8.23	X	X	201.956	15.801	6.519985	173.77	15.706	7.531987	156.8	14.672	7.797619	149.702	14.038	7.814414
FLORIDA	11.09	9.66	10.89	19.68	X	X	512.705	28.178	4.579957	416.82	29.619	5.921621	315.4	27.518	7.270662	264.813	27.58	8.679080
GEORGIA	10.08	13.22	9.02	10.96	X	X	284.994	29.114	8.513045	237.48	30.158	10.58265	193.45	28.453	12.25683	167.265	26.266	13.08602
KENTUCKY	4.79	4.36	5.18	4.85	X	X	196.193	16.321	6.932374	182.39	15.934	7.280187	168.29	15.475	7.662864	163.534	14.975	7.630931
MISSISSIPPI	9.74	10.07	9.29	10.08	X	X	180.377	11.085	5.121218	176.12	9.32	4.409872	168.35	6.657	3.295218	161.182	6.592	3.408156
NORTH CAROLINA	8.53	7.14	8.16	8.89	X	X	246.139	20.762	7.029226	199.57	19.87	8.297005	164.17	18.427	9.353617	150.945	17.068	9.422858
SOUTH CAROLINA	9.13	8.06	9.64	9.00	X	X	127.743	12.168	7.937813	105.52	12.4	9.792772	86.88	11.688	11.21087	81.552	11.752	12.00870
TENNESSEE	8.78	8.28	8.51	13.12	X	X	264.732	14.179	4.463319	229.83	18.51	6.711482	197.05	17.075	7.221094	175.784	15.736	7.459913
ILLINOIS	10.42	10.90	9.85	9.97	X	X	396.691	21.749	4.568837	458.38	22.568	4.102855	396.85	19.579	4.111335	382.329	20.367	4.439240
INDIANA	9.90	11.38	12.83	13.56	X	X	163.199	5.843	2.983576	128.2	5.472	3.556942	108.59	5.464	4.193142	97.161	4.641	3.980507
MICHIGAN	7.58	8.89	7.36	9.05	X	X	398.869	20.965	4.380093	360.96	14.705	3.394882	385.77	14.49	3.130103	359.975	13.455	3.114800
MINNESOTA	10.50	9.67	8.58	10.48	X	X	124	12.086	8.122312	109.79	11.079	8.409236	98.75	9.694	8.180591	92.133	8.104	7.329983
WISCONSIN	10.86	10.83	10.05	9.32	X	X	114.572	9.167	6.667569	92.77	6.904	6.201718	89.12	6.001	5.611348	91.067	8.885	8.130461
ARKANSAS	7.22	5.99	7.06	7.47	X	X	99.778	8.623	7.201821	91.32	8.517	7.772120	84.38	8.386	8.281978	81.213	7.715	7.916426
LOUISIANA	11.82	11.38	10.74	9.15	X	X	250.669	22.209	7.383242	235.12	20.221	7.166908	239.48	17.646	6.140388	233.783	15.599	5.560356
NEW MEXICO	8.82	8.89	7.56	8.55	X	X	74.825	6.711	7.474106	63.45	6.719	8.824534	51.7	5.794	9.339136	47.944	5.402	9.389427
OKLAHOMA	8.62	6.45	7.36	8.92	X	X	133.093	13.321	8.340659	115.96	14.439	10.37642	103.17	12.208	9.860748	100.203	11.807	9.819234
TEXAS	9.24	10.46	10.46	11.83	X	X	877.074	84.177	7.997900	752.57	75.546	8.365335	623.67	73.161	9.775602	518.792	58.002	9.316836
COLORADO	7.72	6.28	7.06	7.79	X	X	103.628	4.878	3.922685	88.11	3.863	3.653577	78.6	3.474	3.683206	75.261	3.303	3.657273
IOWA	10.64	11.82	8.50	10.76	X	X	75.419	5.587	6.173290	70.04	5.701	6.783029	67.37	7.617	9.421849	66.225	6.654	8.372971
KANSAS	8.47	7.99	7.39	6.89	X	X	62.569	4.255	5.667077	54.84	2.823	4.289752	49.73	2.213	3.708358	46.162	2.279	4.114134
MISSOURI	10.39	8.32	8.60	9.77	X	X	208.318	17.306	6.922910	185.13	16.576	7.461424	161.75	16.475	8.487893	130.363	15.868	10.14347
MONTANA	5.52	6.30	6.85	8.75	X	X	23.466	2.616	9.290037	20.12	2.586	10.71074	20.71	2.208	8.884597	21.007	2.257	8.953365
NEBRASKA	14.09	9.62	9.36	9.21	X	X	41.537	3.289	6.598535	38.49	2.595	5.618342	37.03	2.288	5.148978	34.516	2.427	5.859941
NORTH DAKOTA	5.78	5.86	5.56	5.89	X	X	16.942	1.766	8.686499	14.66	1.579	8.975671	13.93	1.405	8.405121	12.614	1.37	9.050790
SOUTH DAKOTA	4.97	4.85	4.00	4.52	X	X	19.824	1.869	7.856638	17.01	1.678	8.220655	17.17	1.57	7.619880	17.092	1.532	7.469381
UTAH	7.60	6.56	7.25	7.12	X	X	42.718	7.176	13.99878	39.06	5.638	12.02850	33.66	4.656	11.52704	31.923	4.653	12.14641
WYOMING	7.90	7.80	9.12	8.65	X	X	11.47	.801	5.819529	10.8	.838	6.466049	9.72	.651	5.581276	9.256	.659	5.933088
ALASKA	10.49	7.38	7.58	8.32	X	X	12.545	3.78	25.10961	9.8	2.428	20.64626	8.1	2.624	26.99588	8.416	2.498	24.73463
ARIZONA	10.58	10.93	11.23	13.35	X	X	153.811	8.394	4.547789	126.23	7.852	5.183659	100.32	10.189	8.463749	68.607	12.314	14.95717
CALIFORNIA	11.07	11.64	10.36	10.71	X	X	833.252	119.847	11.98587	793.27	97.771	10.27088	657.97	82.451	10.44260	557.496	73.969	11.05673
HAWAII	5.06	4.06	3.19	3.85	X	X	36.131	5.182	11.95188	32.62	4.747	12.12702	30.77	3.924	10.62723	29.94	3.338	9.290804
IDAHO	7.85	8.44	9.51	7.18	X	X	23.3	2.769	9.903433	21.12	2.547	10.04972	19.3	2.251	9.719344	18.852	2.291	10.12713
NEVADA	4.82	6.49	7.79	6.83	X	X	36.716	4.088	9.278425	26.22	2.931	9.315408	20.54	2.726	11.05972	17.739	2.467	11.58934
OREGON	8.78	8.28	8.01	9.21	X	X	109.847	4.057	3.077766	97.72	3.807	3.246521	88.37	3.23	3.045905	86.693	4.331	4.163158
WASHINGTON	9.41	10.08	11.22	11.73	X	X	167.946	23.15	11.48683	124.99	18.902	12.60234	129.39	14.319	9.222119	124.057	12.486	8.387274

* Ohio & Guam not included due to data discrepancies

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Table III

Economic Determinants of Welfare Caseload Growth

Moderated by Morris Williamson
Texas Department of Human Services

Forecasting Turning Points in Welfare Caseloads: Economic Determinants in Maryland's Regional Model - Michael Conte, Ph.D., Jane Staveley, M.A., and Fereidoon Shahrokh, Ph.D., University of Baltimore [Oral presentation only]

New Mexico AFDC Caseload Analysis and Forecast: An Inquiry into Record-Setting Case Growth in the 1990s - Jeffrey J. Repichowski , M.A., and Weinong Zhu, M.A., New Mexico Human Services Department [Oral presentation only]

Analysis of the Gaming Industry and Low Wages on Welfare Assistance Caseloads - Diane E. Nassir, Nevada Department of Human Resources

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Forecasting Turning Points in Welfare Caseloads: Economic Determinants in Maryland's Regional Model

Michael Conte, Ph.D., Jane Staveley, M.A., and Fereidoon Shahrokh, Ph.D., University of Baltimore

This paper describes the development of the theoretical framework for a Maryland econometric model, which can forecast turning points in welfare caseloads. The model is a special application of the theory of household choice. An extensive trial and error method yielded super-leading indicators, variables that lead the caseload, which served to predict the onset of employment constraints, which could either intensify (driving members of the at-risk population into reliance on welfare) or ease (providing opportunities for current welfare recipients to find jobs in the private sector) in the near future.

For further information on this study, please contact the authors (see address list).

New Mexico AFDC Caseload Analysis and Forecast: An Inquiry into Record-Setting Case Growth in the 1990s

Jeffrey J. Repichowski and Weinong Zhu, New Mexico Human Services Department

New Mexico Aid to Families with Dependent Children (AFDC) caseloads and expenditures experienced unprecedented growth in the past several years. The current trend began in the late 1980s and continued well into the 1990s. Record-setting caseload and expenditure totals placed additional burdens upon one of the nation's poorer states. What seems to be relief from this rapid expansion began in December 1992, when the AFDC caseload growth rates started to decrease. New Mexico would appear to be following the national economic recovery.

It is the purpose of this paper to analyze AFDC caseload and expenditure behavior since the late 1980s. To that end, the theoretical basis for this pattern will be explored via statistical explications and an investigation of policy changes. Furthermore, forecasting for the next period of time is to be addressed.

AFDC caseloads in New Mexico had been growing dramatically since 1989. Between July 1989 and April 1991, there was a 34 percent increase in cases, which resulted in New Mexico being ranked tenth in the country for case growth. This growth closely correlated with the national trend of increasing AFDC caseloads due to the nationwide recession. It is also a direct consequence of the downturn in the local economy in New Mexico.

October 1990 saw the beginning of AFDC-UP, the federally mandated program for households with an unemployed parent. The addition of this program was a significant factor in pushing up the AFDC caseload. There was approximately a 45 percent increase in total AFDC cases since 1990. Of this increase, about 20 percent of the growth was caused by the addition of the AFDC-UP program. The unemployment situation in New Mexico during that time period affected the dramatic rise in the number of AFDC-UP cases.

According to the United States Census Bureau, the number of poor nationally is at its highest level since anti-poverty programs began in the mid-1960s. Even though personal income growth in New Mexico has been higher than the national level since 1989, the poverty rate for New Mexico increased from 19.5 percent in 1989 to 22.4 percent in 1991. This disparity has to do with the increase in the number of people in low-wage jobs which do not provide medical benefits. Increasing poverty is one of the most important factors which causes growth in the AFDC caseload.

The Lorenz Curve represents household income distribution. For the period from 1980 through 1988, more inequality in income distribution occurred in New Mexico. In 1980, the lowest 25.4 percent of the income-earning households received 2.4 percent of the income, while in 1988, they received only 0.2 percent. On the other hand, the top 11.8 percent of the income-earning households in 1980 received 36.4 percent of the income, but they received 43.5 percent of the income in 1988. Clearly, this skewing has resulted in a significant increase in the number of eligible persons for the AFDC program in this state.

Since 1984, the Medicaid program has been greatly expanded, which has resulted in more women being brought into the system. The expansion of Medicaid eligibility requirements cannot be ignored as one of the reasonable explanations for the increasing AFDC caseload in New Mexico. Clients apply for AFDC and are then certified as Medicaid eligible.

New Mexico is a unique state demographically. Between 1980 and 1990, New Mexico was the eleventh fastest growing state in the United States. Immigration also rose rapidly during that time period. The birth rate for teenage mothers was 29 percent higher than the national average. During 1990, 36 percent of the live births were to single mothers, and the percentage of young participants in AFDC is much higher than the national average. Additionally, the racial and ethnic composition of New Mexico is different from many other states. These factors combine to contribute to the AFDC caseload growth.

The econometric forecasting of AFDC caseloads examined both caseload and expenditure growth. The historical data for AFDC expenditures showed fairly strong seasonality. Both the exponential smoothing and seasonal time series models were utilized, based on data from 1988 to the present. The results indicate that the AFDC caseload growth rate is decreasing. The trend projected by this model coincides with the actual growth pattern in AFDC since December 1992.

The economy in the state of New Mexico is mirroring the national economic recovery. Personal income, employment, construction, and retail sales are all indicating that economic improvement is at hand. Given these improvements in the state's economy, it would be logical to expect a declining AFDC caseload growth rate.

In the long run, the reduction of the AFDC caseload in New Mexico will depend upon a healthy economy and a decrease in the state's poverty rate. New Mexico continues to make efforts towards combating poverty. The problem facing the state in the short run is to effectively and efficiently help those in need. The JOBS and employment and training programs, which lead to self-sufficiency, would be among the most productive approaches to break the cycle of poverty. Ideally, these programs would give families and young people the economic wherewithal to leave public assistance once and for all.

For further information on this study, please contact the authors (see address list).

Analysis of the Gaming Industry and Low Wages on Welfare Assistance Caseloads

Diane E. Nassir, Nevada Department of Human Resources

The Nevada State Welfare Division (NSWD) has established an inverse statistical correlation between the Hotel, Gaming and Recreation (HGR) subcategory of Service jobs within Nevada's establishment based industrial employment, and NSWD's Aid to Families with Dependent Children (AFDC), Child Health Assurance Program (CHAP), Disabled and Food Stamp caseloads. This variable acts as a suppressant to the rise; when low-wage HGR employment drops, as it does due to seasonal trends, recession, adverse acts of nature or due to war, the caseload rises faster; when HGR employment rises, the caseload rises more slowly.

The inverse relationship becomes significant due to the nature of economic expansion in Nevada. Nevada has been the fastest growing state in the nation for the last three decades and will continue to be so to the end of the century along with Arizona. As the tourism economy expands, HGR jobs expand and remain a fairly constant 30% of all Clark County industrial jobs, therefore increasing the number of HGR jobs through time. The more jobs in this category, the more people there will be who are at risk for becoming caseload recipients when employment drops.

NSWD has also established a positive correlation between population and AFDC Basic Public Housing recipients; as population increases, this caseload rises. As long as the nature of the economic and population increases remain unchanged in Nevada, NSWD caseload will continue to grow in good or poor times. The nature of the population growth is generally driven by the nature of the economic expansion; in-migrants's skills, experience and education are reflected in the type of jobs available within the state. Lacking higher education and higher level job skills can put low-end wage earners at greater risk in poor times. Those with diminished skills and resources can be less resilient and are then forced to seek out public assistance earlier in the down turn.

From the work NSWD has done in caseload projections, it is apparent that economic growth by itself is not sufficient to insulate the state from dramatic caseload growth. Conventional wisdom views welfare assistance as a safety net which comes into play largely during economic down times to undergird those who are adversely affected. Nevada does conform to that norm. However, contrary to that conventional wisdom, NSWD caseload increased dramatically during the late 1980s when both Nevada and the nation experienced great economic growth.

Caseload growth in Nevada is a function of several social, political, economic and cultural forces. The following will describe and analyze the interplay of some of these imperatives.

Economic Determinants of Welfare Caseload Growth

Economic and Population Growth

The nature of Nevada's economic growth is telling. HGR comprises all employees within hotels, motels, amusement and recreation. The jobs are basically low-wage, seasonal and marginal in benefits.[1] This sub-category of the service category is larger than any other single category in Nevada. Nevada's industrial based employment (non-agricultural) profile is unique among the nine western states. In 1992, over 44% of all jobs in Nevada's industrial based employment were in the category of service industries. This is the highest of the nine western states which includes Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah and Washington. The other states ranged from a low of about 21% in Alaska and Idaho to a high of over 29% in Hawaii, a state highly dependent on tourism, as is Nevada. When compared to the national average of almost 27%, Nevada's 44% ranks high as well.[2]

HGR jobs accounted for 29% of all jobs statewide at the beginning of the 1980s. By May 1993, such jobs were 26% statewide and 29% in Clark County which encompasses Las Vegas.[3] These proportions will undoubtedly rise later this year as the three Las Vegas mega-resorts open with their 14,000 newly created HGR jobs and 10,500 new rooms.[4]

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[1] Telephone conversation with George Anastassatos, Labor Economist III, Nevada Employment Security Department, April 1, 1993, Carson City, Nevada. Hereinafter cited as Anastassatos, April 1, 1993.

[2] Nevada Business & Economic Indicators, Annual 1992 Issue, Nevada Small Business Development Center, Bureau of Business and Economic Research, College of Business Administration, University of Nevada, Reno, 1993. pps. 13-18.

[3] "Nevada Economic Data" Newsletter, Nevada Employment Security Department, May 1993, Carson City, Nevada.

[4] 1980 - 1992 annual HGR data for Clark, statewide and Washoe Counties comes from a telephone conversation with Brad Benson, Labor Economist III, Nevada Employment Security Department, April 8, 1993, Carson City, Nevada. Please see Exhibit A, attached, "%HGR of Total Est. Based Indust. Emp., CY1980-CY1992," (Carson City, Nevada: NSWD/Research & Statistics).

Economic growth with equity[5] is a key to social, economic and political stability. The marginal nature of the jobs in such a large strata as HGR tends to mitigate against equitable economic growth in Nevada. Nationally, the rate of the working poor increased in the last decade. According to the Census Bureau, 19% of workers earned a low wage in 1979, compared to 26% in 1990,[6] and this increase cut across demographic lines. Among low wage earners with some college training, their numbers increased from 6% in 1979 to 11% in 1990. Low earners are typically young, unmarried, female and African-American or Hispanic.[7] Due to the nature of the typical profile, single female-headed families are hit hardest by low wage earnings. They are most at risk for needing public assistance.

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[5] Strong economic growth coupled with declining income inequality last occurred in the 1960s. The Gini ratio is used by economists to measure the variance from the actual distribution of income against a perfectly egalitarian distribution of income. The lower the ratio, the more egalitarian the distribution; conversely, the higher the ratio the less egalitarian the distribution. From 1960 to 1992, the ratio was at its lowest in the late 1960s and peaked in 1990, subsiding some in 1992 and climbing once again in 1992. David Hage, "The Quest for Camelot," U.S. News & World Report, April 26, 1993, p. 54. See also, Larry D. Hatfield, "Wages erosion frays white collars," San Francisco Examiner, September 8, 1992, p. A1. Hatfield discusses a report authored by Lawrence Mishel, Chief Economist at the Economic Policy Institute (EPI) and Jared Bernstein, a doctoral candidate in social welfare at Columbia University and published by the Economic Policy Institute, a nonprofit Washington, D.C. based think tank, 1992. The authors say, according to Hatfield, that the 1980s experienced a dramatic increase in the income gap between the rich and poor, reversing the diminution of income inequality which had been a trend for the previous three decades. Hereinafter cited as Hatfield, September 8, 1992.

[6] "Workers with Low Earnings: 1964 to 1990," Current Population Reports, Consumer Income, Series P-60, No. 178. U.S. Department of Commerce, Bureau of the Census, March 1992, pps. 1-2, ad passim. The concept of a low earnings threshold was developed specifically for this study and is acknowledged by Census to be subjective but defined by Census as those who have annual earnings which cannot maintain a family of four above the poverty level. The definition includes "those who spend at least 50 weeks during the year at work or looking for work and who either worked 35 hours a week or more or worked fewer hours for nonvoluntary reasons." Only workers who are strongly attached to the labor force, as defined above, are considered in this report. The hourly threshold for 1979 was $3.45 an hour and rose to $6.10 an hour in 1990. The changes over time reflect price movements so that the amounts are actually equal in constant dollars and direct comparisons can be made. According to the Census, the price index used to adjust the thresholds is CPI-U-XI, which is experimental and slows the price rise compared to CPI-U index. "Use of the latter," says the Census, "would make the thresholds higher for later years and would increase the number of low-earner workers." Readers are referred to Appendix A of this study for more information about price indexes.

[7] "Low-Wage Workers Growing Rapidly," American Demographics, July 1992, p. 12. See also Hatfield, September 8, 1992. Hatfield relates that the EPI report cited above, says that American wage earners have experienced a decade of erosion in real wages which, by the end of the decade, had spread to the college-educated, women and white collar workers. Hatfield reports that during the 1980s, the already low wages of low income male workers fell almost 16% while low income female worker's wages fell almost 7%. Female wages are lower than males to begin with. Wages fell at the same time that the nation experienced 26 consecutive quarters of growth from 1983 - 1989. One of the problems with the GNP and now the GDP (the GDP replaced the GNP in 1991) is that they do not address the nature of economic growth and kinds of jobs created. According to Theresa Feren, NSWD Reno District Office Manager, anecdotal evidence from the NSWD Eligibility Certification Specialists' observations shows more middle class applying for first-time assistance during the current recession, especially medical. Telephone conversation with Terry Feren, April 23, 1993.

The rate of single parent families, over 85% of which are headed by females,[8] increased over the last decade from 19% to 22%.[9] According to the 1990 Census, 44.5% of all single female headed families with children under 18 lived below the poverty line. Impoverishment is endemic in this group as 43.8% of such families were below poverty in 1970.[10] In Nevada, over 31% of all female headed households with related children under the age of 18 are below poverty; the figure rises to almost 45% in such households with related children below the age of 5.[11] Over 96% of all Nevada's AFDC Basic caretakers, (age 18 and over) are female; the same proportions hold for all adults.[12] No matter what vantage point is used to measure, children and adult females constitute the overwhelming majority of welfare recipients.

Compounding the devastating effects of wage erosion for low-end families is the decline of personal net worth. A downward spiral is created as these families dip into savings in order to meet expenses. As wealth diminishes, the ability of a family to weather unemployment or illness is reduced and the family inexorably slides into poverty. Over the last decade, wealth, that is, the net value of assets defined as stocks, savings accounts and housing less debt, was accumulated in increasingly fewer hands. The Federal Reserve Board reported that from 1983 - 1988, the net worth of families earning over $50,000 a year increased $9500, over 5%, while the net worth of those earning less than $10,000 declined $1500, almost 40%. Those in the middle remained constant.[13] By the beginning of this decade, the top 20% of the population controlled 78% of the personal assets, the bottom 40% had only 3% of the wealth, and the middle 40% controlled only 19%.[14]

The nature of population growth can fuel caseload growth. Nevada's population increase is due largely to in-migration which is driven by both push and pull dynamics. Californians, fleeing polluted air, congestion, crime and loss of opportunity, constitute 25%[15] of Nevada's in-migration. Newcomers are lured by a lack of state income tax, more affordable housing, clean air, low density with its concomitant benefits and the promise of economic opportunity. Historically, migration is driven by a desire for the "main chance". Given the nature of opportunity in Nevada, the occupational and educational level of Nevada's in-migrants should be varied; however, the preponderance of HGR jobs require only low level or no skills, and little to no education or experience. Compounding the problem is the fact that there are always many more applicants than HGR jobs. NSWD necessarily needs to provide assistance to those who get the jobs as well as those who do not.

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[8] U.S. Bureau of the Census, Statistical Abstract of the United States: 1992, Table No. 66. "Families, by Number of Own Children Under 18 Years Old: 1970 to 1991," 112th Edition, (Washington, D.C.: U.S. Government Printing Office, Superintendent of Documents. 1992). p. 53.

[9] Sonya Ross, "Single-parent families up," Nevada Appeal, September 14, 1992, p. A8.

[10] Census and You, U.S. Bureau of the Census, November 1991, p. 10.

[11] Betty McNeal, 1990 Census Extract from Summary Tape File 3A, Table 3. "Income and Poverty Status in 1989: Nevada," (Carson City, Nevada: Nevada State Data Center) May 7, 1992. p.3.

[12] Nevada Department of Data Processing system report for NSWD, WL00469-2, "Demographic Caretaker Report," Total Housing AFDC Cash, run date 3/31/93, and WL00469-4, "Demographic Adult," total Housing AFDC Cash, run date 3/31/93.

[13] Reno Gazette Journal, January 8, 1992, p. 7A, from a report of the U.S. Federal Reserve Board, January 1992.

[14] Sacramento Bee, December 22, 1991, p. 14.

There are 102 occupations within the HGR strata. The vast majority are in the lower end, such as waitresses/waiters, maids/janitors, dining room attendants, food preparers, card dealers, change attendants, bartenders, guards and office workers. The far fewer higher end executive jobs have little impact on the average wage for this strata.[16]

Clark County accounts for almost 64% of the population, and according to NSWD estimates, Clark has the majority of the NSWD caseload: 74% of all NSWD AFDC grant recipients; 58% of the CHAP eligibles; and, 72% of Food Stamp recipients.[17] As Clark County drives the state economically, politically and socially, the following discussion on wages will be confined to Clark County.

The last annual wage survey conducted by the Nevada Employment Security Department (NESD) was March 1, 1992. A survey of the major occupations listed above shows HGR wages ranging from a low of about $4.30 an hour to about $11.00.[18] There are 2080 hours in an employment year. A five dollar job pays $10,400 a year while an eight dollar job pays $16,640.

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[15] Dan Frost, "Nevada Without Gambling: Californians are Flocking to Nevada in Search of Small-Town Calm," American Demographics, December 1990, p. 47. Frost quotes Maud Naroll, Nevada State Demographer, that one in four newcomers to Nevada comes from California.

[16] Anastassatos, April 1, 1993.

[17] Population figures from Maud Naroll, "Nevada Population Estimates (1992) and Forecasts (1993-1997)," Nevada State Demographer, Bureau of Business and Economic Research, College of Business Administration, University of Nevada, Reno, April 6, 1993. Hereinafter cited as Naroll, April 6, 1993. Caseload estimates for AFDC, CHAP and Food Stamps from Department of Data Processing system report for Nevada State Welfare Division, WL00427, run date 6/30/93.

[18] Anastassatos, April 1, 1993.

HGR wages average about 16% less than those for all jobs combined.[19] According to NESD, the total annual average wage in Clark County in 1990 was $22,265, while the average for HGR was $18,813. In 1991, these figures rose to $22,856 and approximately $19,100, respectively.

More specifically, according to NESD, hourly wages in Clark County for waitresses and waiters are $4.93-8.31; card dealers receive $4.30-5.67; dining attendants make $5.03-7.63; change attendants earn $5.77-8.54; guards earn $7.45-11.04 and bartenders make $8.05-10.46.[20] In some of these jobs, employees also receive tips.

The U.S. Department of Health and Human Resources 1993 poverty line for a family of four is $14,350[21] which means one wage earner for a family of four earning $6.90 an hour or less. From the above information, it is evident that many jobs in Clark County and in tourism statewide pay less than is needed to remain above the current poverty line.

There is some debate as to the validity of the current method of determining poverty. The original method was established in 1955 and indexed to the cost of food, which went through inflationary spirals in the early 1950s. In 1969, with the intent of defining more people below poverty, the method was revised by indexing poverty to the Consumer Price Index (CPI). However, a recent study done at the University of Arizona, demonstrates that the revised method, due to changing market conditions, actually achieved the opposite and kept more people from being defined below poverty. For example, the poverty line in 1990 for a family of four was about $13,000; if the original calculation had been used, that figure would rise to over $20,000.[22]

In 1989, using the revised method, 31.5 million people were defined as living in poverty. Two million were year round full-time workers. If the original computational method were used, this number would increase by about 50% raising the number of full time workers below poverty to six million.[23] When the effects of the current recession are noted, the above 31.5 million below poverty in 1989 became 33.6 million in 1990 and rose to 35.7 million in 1991. The poverty rate grew from 13.5% in 1990 to 14.2% in 1991.[24] In the national political arena, the debate over the computation of poverty cleaves along partisan lines. The discussion could heat up in the months to come. If poverty is redefined, Nevada and the nation will experience a proportional increase in Welfare and Medicaid caseloads.

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[19] Telephone conversation with Mike Clarke, Labor Economist III, Nevada Employment Security Department, April 20, 1993, Carson City, Nevada. Hereinafter cited as Clarke, April 20, 1993.

[20] Anastassatos, April 1, 1993.

[21] Federal Register, Vol. 58, No. 28, Friday, February 12, 1993. p. 8288.

[22] Mike Clarke, "Determining the Poverty Line," Economic Update, 4th Quarter 1992, (Carson City, Nevada: Nevada Employment Security Department), p.9.

[23] Ibid.

Economically, throughout calendar year 1987, Nevada was very strong within the national context in terms of industrial employment growth. At the end of the last quarter of that year, and for most of the year, Nevada finished as the leader in industrial employment growth nationwide.[25] Significant development continued in Clark County as the Mirage and Excalibur were under construction. Over seven thousand new rooms came on line in late 1989 and early 1990 with a significant jump in HGR employment of well over 11,000 new jobs.[26]

As population growth is generally fueled by economic growth,[27] Nevada's population grew at the rate of 6% a year during the late 1980s but, as the recession developed, dropped to under 5% for 1991 and less than 4% for 1992.[28] The bleak opportunities in Nevada coupled with the deepening of the recession in California served to slow the state's growth. However, as the three current mega-resorts move through construction and opening, population rate of growth should increase as the approximately 10,500 new rooms and 14,000 new HGR jobs become available. Rooms have been increasing from 62,440 in 1988 to 86,000 in 1992 with a concomitant rise in jobs.[29]

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[24] Census and You, November 1992, Volume 27, No. 11 (Washington, D.C.: Bureau of the Census, U.S. Government Printing Office) p. 7.

[25] "Nevada Economy, 4th Quarter, 1987," Economic Update, 4th Quarter, 1987, (Carson City, Nevada: Nevada Employment Security Department), p.1.

[26] Clarke, April 20, 1993.

[27] Ed Vogel, "Unemployment blamed on growth," Nevada Appeal, November 3, 1991, p. 1A, in which Vogel quotes Maud Naroll, Nevada State Demographer, as saying "People tend to follow jobs. Job growth has been one of the major driving factors in our population growth." See also, Ed Vogel, "Population of Nevada sees growth slow," Nevada Appeal, November 1, 1992, p. 1 + 12. Vogel quotes Maud Naroll, "Job growth is down and as a result the population growth slowed."

[28] Maud Naroll, "Percent Growth in Population, 1981-1992, Nevada State Estimates," Nevada State Demographer, Bureau of Business & Economic Research, College of Business Administration, University of Nevada, Reno, January 19, 1993. Hereinafter cited as Naroll, January 19, 1993.

[29] Clarke, April 20, 1993.

NESD estimates that the MGM construction alone will generate 7,000 HGR jobs directly and another 20,000 jobs indirectly.[30] There will be many more applicants than jobs. NSWD resources will need to assist those who failed to acquire jobs as well as those who do.

NSWD Caseload Growth

NSWD caseloads kept pace with the economic and population growth. While other states in the nation generally experienced a leveling off or decline in caseload as the economy expanded late last decade, Nevada's grew at unprecedented rates, driven by the nature of the economic and population growth occurring within the state.

AFDC cash grant recipients increased about 15% a year from 1988 through 1991; 24% from 1992 over 1991 and slowed increasing about 10% 1993 over 1992. NSWD is projecting about a 14% increase a year over the next two years.

CHAP grew nearly 475% from 1989-1990, well over 200% from 1990-1991, 110% 1992 over 1991 and about 71% 1993 over 1992. CHAP is projected to increase about 23% next year.

In Nevada, Medical payments to the Disabled represent the highest cost per recipient of all Medicaid programs. The fastest rising group of eligibles is occurring within the working age population.[31] Disabled eligibles increased 10 to 15% per year from 1987 through 1991, 20% 1992 over 1991 and again 1993 over 1992. Disabled is projected to increase about 18% a year for the next two years.

Food Stamp participating persons have been increasing at a rate of over 20% per year since 1989 (with a 29% increase from 1991 to 1992) 20% again 1993 over 1992 and is projected to increase about 21% a year for the next two years.[32]

Eligible Nevada Food Stamp recipients exhibit greater need and have fewer resources than those in other states. Food Stamp eligibility determination is standard throughout the contiguous 48 states thereby making the average monthly benefit per person a useful index to the economic well-being of states within a comparative framework. Such an analysis reveals that Nevada was the highest from FFY1988 through FFY1992, with the exception of FFY1990 (second to Illinois).

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[30] Ibid.

[31] Diane Nassir, "Program Analyses: CHAP, Disabled, Food Stamps, ADC," (Carson City, Nevada: NSWD/Research & Statistics). February 18, 1993. Disabled section, p.5. Hereinafter cited as Nassir, "Program Analyses".

[32] All references in this paper to NSWD increases over time as well as projected growth, see "Change Over Time: Medicaid Eligibles (with Retros) Food Stamp (Participating Persons) and CSE," (Carson City, Nevada: NSWD/Research & Statistics), August 3, 1993.

The average monthly benefit per person in Nevada ranged from $58.79 in FFY1988 to $77.63 in FFY1992.[33]

Statistical Correlation between HGR and Caseload

In December 1986, NSWD developed simple and multiple linear regression models to project caseloads. At the time, Nevada was one of only a handful of states which used multiple regression to project AFDC. The NSWD AFDC model was built upon the work of those on the cutting edge of welfare model development.[34]

NSWD uses multiple regression models to project AFDC Basic, AFDC-UP, CHAP, Disabled, Child Welfare and Food Stamps. Simple linear regression models are used to project Aged, Blind, some aspects of Disabled, and Child Support Enforcement. All of the variables NSWD uses must be statistically significant at the 95% confidence level. Many are statistically significant at the 99.9% confidence level.

In the fall of 1989, NSWD developed HGR as an employment variable and immediately incorporated it into the AFDC Basic, CHAP and Food Stamp models. Eventually HGR was also added to the Disabled and AFDC-UP models. In all models, HGR has an inverse relationship to the caseload: as employment in HGR decreases, NSWD caseload rises faster.

NSWD runs the projection models monthly and projects out to the end of the current biennium, in this case through state fiscal year 1995. The July projections of each year are know as the "baseline" projections and are tracked over time for accuracy in predicting one, two and three years out.

Nevada's AFDC baseline models has been exceptionally strong. From 1989 - 1991, the AFDC projection was within +/- 1.2% of the actual for the first year out. The second year was from within +/- 0.2% to 5.8% of the actual. The 1992 baseline projection for FY1993 overprojected 4.8% as caseload growth slowed. I believe that this was due to the deepening of the recession in California as well as in Nevada; Californians stayed put as prospects dimmed in Nevada. This is supported by the fact that Nevada's rate of population growth slowed that year as well.

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[33] Nassir, "Program Analyses," Food Stamp section, p.1. The raw data for these statistics comes from FNS-388/250.

[34] NSWD models were based on the work done by Robert D. Plotnick and Russell M. Lidman, "Forecasting AFDC Caseloads," Public Welfare. Winter 1987, pps. 31-35 + 46. At the time, Plotnick was Associate Professor of Public Affairs and Social Work at the University of Washington, Seattle, Washington. Lidman was Director of the Washington State Institute for Public Policy, Olympia, Washington. Their work was supported by the Washington State Department of Social and Health Services. They cited the work of Jean Baldwin Grossman, "The Technical Report for the AFDC Forecasting Project," prepared for the Social Security Administration by Mathematica Policy Research, February 1985. This study developed forecasting models for national AFDC caseloads. This puts NSWD's model in the mainstream. At the time only a handful of states used multiple regression analysis to project AFDC. One year after the models were developed, Nevada's AFDC program began its rapid ascent. It was very fortunate that a good statistical model was in use at the beginning of this rise.

Models for Aged, Blind and Disabled are very good over time. The Food Stamp model has been underprojecting for the second year out. The CHAP model has been greatly underprojecting but overprojected in 1992 due to a slow down in growth.

Any model's ability to predict the future is based on the extent to which the future looks like the past. The more volatile the growth, the more difficult it is to project accurately.

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The Nevada experience demonstrates that economic growth alone does not necessarily insure a desired standard of living; the nature of economic growth plays an important role in establishing the quality of life Americans have come to expect.

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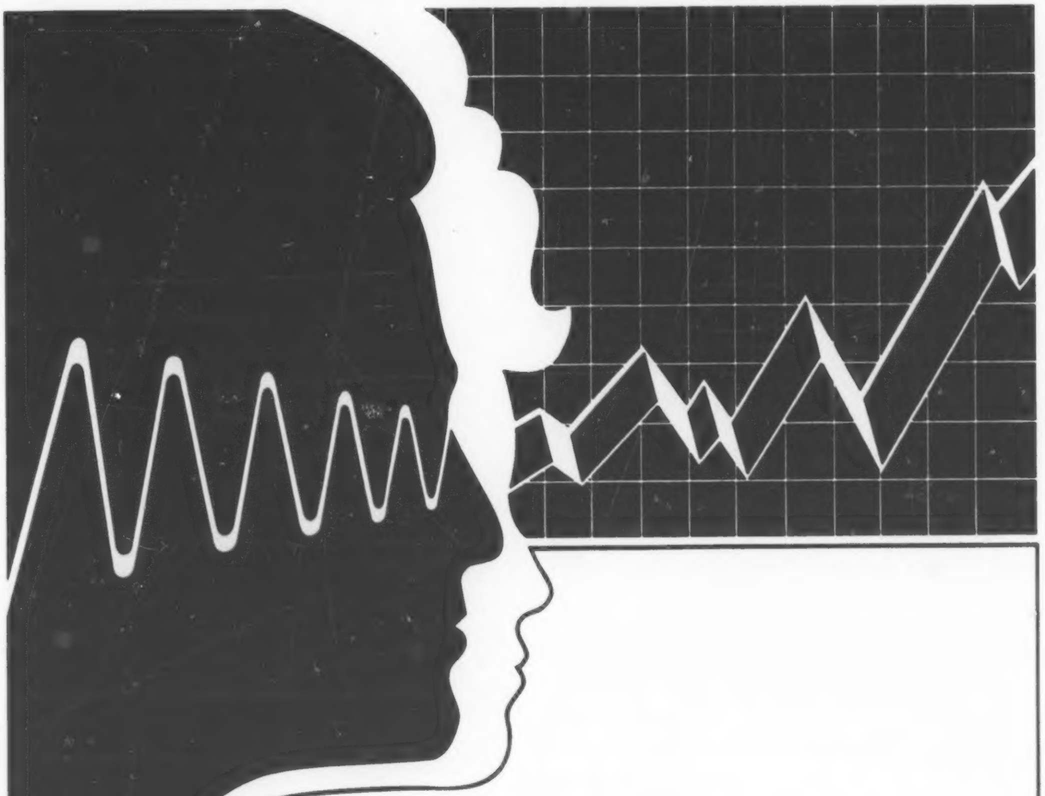

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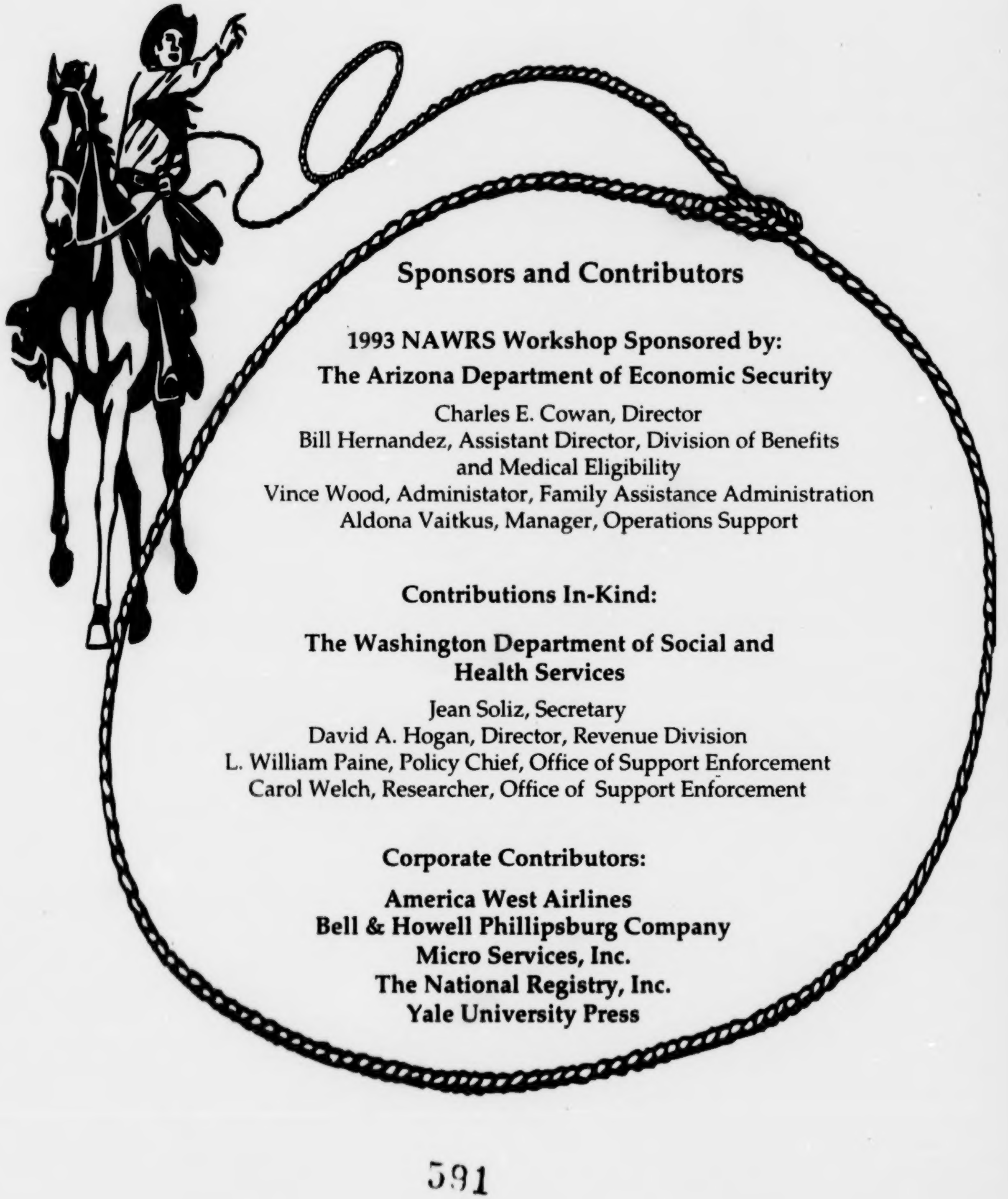

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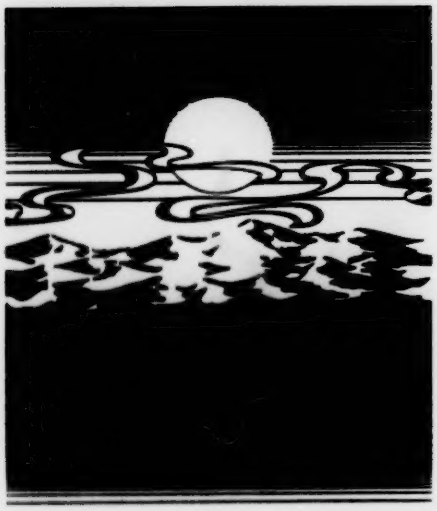

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